Aetna Select Tennessee

Summary Plan Description

As of January 2009

#H000066148

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Eligibility

Employee

Generally, you are eligible for LifeTimes Benefit Choices if you are an active full-time or part-time employee as designated by your facility. Temporary employees, seasonal employees, leased employees, PRNs and independent contractors are not eligible. You are eligible for long-term disability coverage if you are a full-time employee and are regularly scheduled to work at least 32 hours per week.

Generally, coverage begins the first of the month following two months of service. In some facilities, coverage may begin sooner. When you are eligible for benefits enrollment, view your actual Benefit Effective Date by logging on to LifeTimes Connection at HCArewards.com, calling 1-800-566-4114 or reviewing your enrollment materials.

It is important for all eligible employees to understand that if you do not elect coverage, you will be assigned default coverage.

Dependents

When you become eligible to participate in the following benefit programs, you may enroll your eligible dependents for coverage in these programs:

- Medical
- Dental
- Vision
- Dependent Life Insurance

Your eligible dependents include:

- Your legal spouse, unless you and your spouse are legally separated or divorced
- Your common law spouse, in states that recognize those unions
- Your eligible domestic partner (see additional requirements below)
- Your unmarried eligible dependent children

Eligible Dependent Children

Your eligible dependent children are your **Children**, as defined below, who fall into one of the dependent categories outlined below:

Dependent Categories:	Required Documentation:
Children under age 19.	A birth certificate will be required when adding a dependent to coverage.
Children age 19 or over but under the age of 26 who are students regularly attending an accredited school.	A birth certificate and an official student transcript will be required each year to verify eligibility.
Children age 19 or over but under the age of 26 who meet all 3 of the following requirements: • Live in your household in a parent/child relationship, • Earn less than 200% of federal poverty guidelines for a single person, and • Not eligible for any other group health or life insurance coverage.	A signed affidavit regarding dependent status, a birth certificate and copy of Child's Federal Tax Return will be required.
Children who become physically or mentally disabled while covered and remain disabled, regardless of their current age.	Call LifeTimes Connection at (800) 566-4114.

Your **Children** are defined as your unmarried:

- Biological children
- Adopted children
- Children placed with you for adoption
- Children covered by a Qualified Medical Child Support Order (QMCSO).
- Stepchildren and children under your legal guardianship who are dependent on you for support. If they are under age 19, they must also live in your household in a parent/child relationship at least 50% of the time.
- Children of eligible domestic partners (defined below).

Note: If you are in the state of Florida, different dependent eligibility rules may apply to you. Call LifeTimes Connection at (800) 566-4114 for more information.

Eligible Domestic Partner Dependents

You may also enroll your domestic partner and the children of the domestic partner provided you and your domestic partner:

- Both are members of the same sex in a committed relationship or both are opposite sex in a committed relationship and one or both are age 62 or older and one or both meet the criteria for Social Security benefits for old-age or aged individuals; and
- Share a common residence; and
- Agree to be jointly responsible for each other's basic living expenses incurred during your domestic relationship; and
- Neither is married or a member of another domestic partner relationship; and
- Both are at least 18 years of age and capable of consenting to a domestic partner relationship; and
- Neither is related by blood that would prevent either from being married to each other; and
- Neither has previously filed a Declaration of Domestic Partnership that has not been revoked.

"Basic Living Expenses" means shelter, utilities and all other costs directly related to the maintenance of the common household of the shared residence of the domestic partners. It also means any other cost, such as medical care, if some or all of the cost is paid as a benefit because a person is another person's domestic partner. "Jointly responsible" means that each partner agrees to provide for the other partner's basic living expenses if the partner is unable to provide for him/herself. Persons to whom these expenses are owed may enforce this responsibility if, in extending credit or providing goods or services, they relied on the existence of the domestic partnership and the agreement of both partners to be jointly responsible for those specific expenses.

To enroll the domestic partner, you and your domestic partner must sign and have notarized the Declaration of Domestic Partnership affidavit. You may call LifeTimes Connection at 800-566-4114 to obtain the affidavit. (For California, you may use the state affidavit.) The affidavit must be executed and notarized within 31 days of the establishment of the domestic partner relationship and fulfillment of the requirements above. You must mail the affidavit to LifeTimes Connection, P.O. Box 785012, Orlando, FL 32878-5012. You may also add your domestic partner at annual enrollment provided the affidavit is submitted during the annual enrollment period.

When the affidavit is executed, notarized and submitted to LifeTimes Connection, both of you agree:

- To notify LifeTimes Connection immediately if the domestic partner relationship terminates;
- The value of domestic partner (including children of the domestic partner) will be treated as income to the HCA-Affiliated Facility plan participant;
- Any misrepresentation may result in loss of benefits and/or termination of employment;
- Any person or company which suffers a loss as a result of a misrepresentation in the affidavit, or because of any misrepresentation of eligibility for domestic partner status, may bring a legal action against both of you, jointly or separately, to recover any loss, including reasonable attorney fees and other expenses of a suit;
- Proof of a domestic partner relationship will be provided when requested;
- The implementation or termination of this domestic partner relationship may affect the insurance coverage and other benefits of both parties; and
- The Plan Administrator reserves the right to modify or terminate domestic partner benefits at any time without the consent of any plan participant.

If you only wish to enroll the child(ren) of the domestic partner, both of you will still need to execute, notarize and submit the Declaration of Domestic Partnership affidavit to LifeTimes Connection before such child(ren) may be added.

The rules regarding "No Double Coverage" also apply to domestic partner relationships where both parties work for HCA-Affiliated Facilities.

Local HMO coverage provisions may apply concerning coverage for domestic partners and the child(ren) of the domestic partner; check with your local HMO to determine coverage provisions for domestic partners and their dependents.

Dependent Verification Process

The purpose of the Dependent Verification Process is to make sure we provide high-quality, cost-effective healthcare coverage to eligible employees and their dependents.

Documentation Required When Enrolling a New Dependent

Dependents added to coverage must complete an eligibility verification process. When an employee enrolls a new dependent, they will receive a notice from LifeTimes and will be required to submit appropriate documentation. Participants have 31 days from the date they elect dependent coverage to return the appropriate documentation. If verification is not completed by the deadline, LifeTimes will retroactively drop the dependent as of the coverage effective date.

Random Dependent Eligibility Audits
LifeTimes conducts random checks to make sure only eligible dependents are covered. Severe penalties, including the loss of coverage and liability for repayment, could apply if you knowingly attempt to cover or continue to cover anyone who is not eligible.

During the random check process, LifeTimes will select a percentage of participants covering any type of dependent and require them to submit documentation of eligibility (includes spouse, common law spouse, dependent child, student, domestic partner, domestic partner child).

If a participant was previously selected for the audit but did not provide appropriate documentation and was dropped from coverage, they must provide the documentation before adding the dependent to coverage during annual enrollment.

Participants must submit the required documentation by the deadline indicated by LifeTimes. If you do not respond by the date indicated, the dependent will be dropped from all coverages. Coverage may be reinstated once the participant submits the required documentation.

Special Note for Dependent Coverage

Please be sure your dependents are eligible if you choose a Medical or Dental HMO under the rules of that organization. These additional eligibility terms can be found in the document provided by the HMO. Severe penalties, including loss of coverage, and liability for repayment, could apply if you knowingly attempt to cover or continue to cover anyone who is not eligible. HCA reserves the right to request proof of dependent status.

If you elect a Medical or Dental HMO that has different dependent eligibility rules or definitions than stated in this SPD and you later elect a medical or dental PPO option that follows the rules stated above, a dependent may lose coverage. If you are considering changing coverage options, you should pay close attention to the dependent eligibility provisions to be aware of whether your new plan election has the same dependent eligibility provisions. If you have any questions, call LifeTimes Connection at 1-800-566-4114.

Coverage for Disabled Dependents

You may be eligible to cover or continue coverage under the Medical Plan, Dental Plan or Dependent Life Insurance Plan for your unmarried dependent child beyond the dependent eligibility age if that child is physically or mentally disabled and not capable of self-support. (A child with a learning disability is not considered physically or mentally disabled.) Call LifeTimes Connection at 1-800-566-4114 for more information.

You may continue coverage for a disabled child until one of the following events occur:

- Your coverage under the plan ends
- The child's disability ends
- The child marries
- You fail to provide proof when requested that the disability continues
- Your disabled child fails to undergo any physical examination required as proof of continuing disability

Contact LifeTimes Connection for specific rules for the Medical and Dental Plans.

No Double Coverage

If you are eligible, you may choose coverage as an employee or as a dependent of another employee, but not both. In addition, children can be covered as dependents of only one employee. So, for example, if you and your spouse both work for HCA-Affiliated Facilities, you would have the following options:

- Each of you may be covered separately as employees and one of you may elect to cover any dependent children;
- One of you may waive coverage and be covered as a dependent, along with any eligible children, under the other spouse's coverage; or
- Each of you may waive coverage, provided you have coverage elsewhere.

You cannot be eligible for coverage at more than one HCA-Affiliated facility at the same time.

If you double cover yourself or your dependents, double benefits will not be provided under any of the LifeTimes Benefit Choices plans.

Qualified Medical Child Support Order

LifeTimes Benefit Choices plans will comply with the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is a judgment, decree, order (including approval of a settlement agreement) or administrative notice issued pursuant to a state domestic relations law or a national medical support notice (as defined by ERISA) from a court or administrative body

directing a health plan to cover a child of a participant under the group health plan(s). Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO.

When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the plan's procedures for determining if the order is valid. Coverage under the plan pursuant to a QMCSO will not become effective until the Plan Administrator determines that the order is a QMCSO. If you, your children or their authorized representatives have any questions or would like to receive a free copy of the written procedures for determining whether a QMCSO is valid, please contact LifeTimes Connection.

Other Coverage

If you have coverage available under another health plan (for example, coverage under your spouse's employer plan), you should consider whether you or your dependents should be covered under the HCA Medical Plan and the other health plan. If the other health plan is the primary plan, it is unlikely that the HCA Medical Plan will pay benefits as the secondary carrier. Refer to the Coordination of Benefits section for more information.

Participation

Enrollment

New Hire Enrollment
After you begin working and become eligible for benefits, you will receive enrollment information in the mail. Access additional information about your benefits options and the cost associated with each by logging on to LifeTimes Connection at HCArewards.com.

Default Coverage
If you do not elect coverage when you are eligible, you will receive – and pay for – a set level of benefits called "default coverage."

To enroll in or decline coverage for yourself or your dependents by the date shown on your enrollment materials, you can access the LifeTimes connection Web site at HCArewards.com or call LifeTimes Connection at 1-800-566-4114.

Once you enroll, you generally cannot change your choices until the next annual enrollment period — unless you have a qualifying change in status, qualify for a "special enrollment" period, or LifeTimes Benefit Choices allows you to make a change.

If you do not enroll by the date shown on the LifeTimes Connection Web site, you will automatically be enrolled in the default coverages shown below. The cost of this coverage will be deducted from your paycheck on a before-tax basis.

Full-Time Employees
If you are a full-time employee and you do not enroll, your default coverage is the Smart Care Base Plan, employee-only coverage. Some facilities in East Florida have a different medical default to the EPO option. If this default applies to you, it appears on your list of benefits options when you log on to LifeTimes Connection at HCArewards.com.

Benefits	Default Coverage
Medical Plan (including prescription drugs)	Smart Care Base Plan (employee only)
Employee Life and AD&D	One times base pay
Dental Plan	No coverage
Vision Plan	No coverage
Flexible Spending Accounts	No coverage
Supplemental Life	No coverage
Dependent Life	No coverage
Long-Term Disability	No coverage
CorePlus Voluntary Benefits	No coverage

Part-Time Employees: If you are a part-time employee and you do not enroll, your default coverage is the "no coverage" option for all coverages.

Annual Enrollment

You have the opportunity to change your benefit elections each year during annual enrollment. The annual enrollment period typically occurs in the fall for coverage that will be effective the following January.

Before the annual enrollment period begins, you will receive materials to help you make your benefit choices and complete the enrollment process.

Please review this information and contact LifeTimes Connection for answers to your questions. You must contact LifeTimes Connection, online or by phone, before the annual enrollment deadline to make any changes to your coverage for the upcoming plan year. Otherwise — except for your participation in a Flexible Spending Account — the coverage options you had in effect during the current plan year will automatically continue, including default elections, throughout the upcoming plan year (if those options are still available). If the medical option is not available (such as a change in HMO option) and you do not make an annual enrollment election, you will default to the Smart Care Base Plan. If you want to participate in a Flexible Spending Account, you must enroll each year and specify your contributions for the upcoming year.

Once you make your choices for the upcoming plan year, you will not be able to make any changes to your coverage until the next annual enrollment period — unless you have a qualifying change in status, qualify for a "special enrollment" period, or LifeTimes Benefit Choices allows you to make a change. For more information, refer to the Making Changes During the Year section.

Evidence of Insurability

If you decline Employee Life Insurance, Dependent Life Insurance or Long-Term Disability coverage when you are first eligible in LifeTimes Benefit Choices but decide during a subsequent annual enrollment that you want to add one or more of these options or increase your level of coverage, you may be required to provide evidence of insurability. You may also be required to provide evidence of insurability if the change is due to a qualifying change in status.

To provide evidence of insurability, you'll need to complete a form that contains questions about your or your dependent's health and medical history. LifeTimes Connection will send the form directly to you if evidence is required. Once you complete the Evidence of Insurability form, send it to the carrier providing coverage in the envelope provided. If approved, your new coverage will become effective on the first of the month following the carrier's approval or on January 1, whichever date is later.

Special Enrollment Rights

Special enrollment rights allow you and/or your dependents to enroll in or drop medical coverage without waiting until annual enrollment, if certain events occur. Special enrollment applies only to medical coverage. You have only 31 days to request enrollment by contacting LifeTimes Connection.

Declining Coverage

If you decline coverage because you or your dependents have **group health** coverage elsewhere, you may be eligible for special enrollment if one of the following events occurs:

- You gain a dependent through marriage, birth, adoption or placement for adoption
- You and/or your dependents lose eligibility for other group health coverage for reasons including:
    - Legal separation
    - Divorce
    - Death
    - Termination of employment
    - Reduced work hours
- The employer contributions to the other group healthcare coverage stop
- The other coverage was COBRA coverage and the maximum COBRA coverage period ends

Coverage is generally effective the date of the event.

Marriage

Even if you are not currently enrolled in LifeTimes Benefit Choices medical coverage, you may enroll yourself and your new dependents (spouse and children) within 31 days of your marriage. Coverage will be effective on the date of the marriage if you provide enrollment information to LifeTimes Connection within 31 days of the marriage.

Birth, Adoption or Placement for Adoption
Even if you are not currently enrolled in LifeTimes Benefit Choices medical coverage, you may enroll yourself and your new child within 31 days of the birth, adoption or placement with you for adoption. If your spouse is not enrolled in the plan, you may enroll him or her when you enroll your new child. Coverage is retroactive to the date of birth, adoption or placement for adoption.

Making Changes During the Year

Generally, once you make your benefit choices, you may not change them until the next annual enrollment period. But there are some limited exceptions, described in the following sections. The general rule is that you cannot change your elections until the next annual enrollment — so choose carefully. These exceptions may or may not apply to all LifeTimes Benefit Choices elections.

If you believe you may fall within one of the limited exceptions, and you need to change your election during the year, you must do so within 31 days of the event that causes the exception to occur. LifeTimes Benefit Choices determines eligibility for any change discussed in this section.

Contact LifeTimes Connection at 1-800-566-4114 as soon as possible to make the appropriate changes.

Family Events
You may change your LifeTimes Benefit Choices election during the year if one of the following family events affects your, your spouse's or your dependent child's eligibility with respect to that coverage. Any election change must be consistent with the family event allowing the change.

Remember, it is not enough just to have an event occur. The event must affect eligibility, and the election change must be consistent with that event. Family events are:

- Your marriage, divorce, legal separation or legal annulment, or the death of your spouse
- Dissolution of common law marriage through court proceeding
- Your dependent child's birth, death, adoption or placement with you for adoption
- Your dependent child becomes eligible or ineligible for coverage due to his or her age, student status, marital status or any similar circumstance
- A change in your, your spouse's or your dependent's residence that affects that person's eligibility

Job Events
You may change your LifeTimes Benefit Choices election during the year if one of the following job events affects your, your spouse's or your dependent child's eligibility with respect to that coverage. Any election change must be consistent with the job event allowing the change. Remember, it is not enough just to have an event occur. The event must affect eligibility, and the election change must be consistent with that event.

Job events are:

- A termination or commencement of employment
- A strike or lockout
- A commencement of or return from an unpaid leave of absence
- A change in worksite
- Any other change in employment status with the consequence that the person becomes or ceases to be eligible for a benefit

Qualified Medical Child Support Order
Coverage for a child may not be terminated unless other healthcare coverage is actually provided.

Family and Medical Leave Act (FMLA)
If you take FMLA leave, you may change your election with respect to Medical, Dental and Health Care Flexible Spending Account coverage. For more information, see If You Take a Leave of Absence.

Day Care Flexible Spending Account Cost Changes
For your Day Care Flexible Spending Account, significant cost changes that may allow you to change your contributions include:

1. Selecting a different dependent care provider
2. Increasing the cost of your provider
3. Increasing or decreasing the hours (and thus the cost) of the provider

The information described above does not apply to your Health Care Flexible Spending Account.

Other "Cafeteria" Plans
If the employer of your spouse, former spouse or dependent child offers a "cafeteria" or "Section 125" plan that has a period of coverage different from the calendar year or that allows the same election changes as listed above, you may change your benefit election to correspond with an election or election change made under that other cafeteria plan. Your election change must be on account of and must correspond with that other election. Also, the other cafeteria plan must allow this type of change. The information described above does not apply to your Health Care Flexible Spending Account.

Automatic Changes
If the cost of your underlying coverage increases or decreases, the plan may automatically change the amount of your before-tax premium contribution that is withheld. Likewise, the plan may automatically change the amount of your deduction if it is required to do so by the terms of a QMCSO or by the terms of another judgment, decree or order that requires the plan to provide coverage for your dependents.

Medicare or Medicaid
If you, your spouse or your dependent child is enrolled in group healthcare coverage and also becomes entitled to Medicare or Medicaid coverage (other than Medicaid coverage solely for pediatric vaccines), you may change your election to cancel or reduce group healthcare coverage of that person. Similarly, if that person loses entitlement to Medicare or Medicaid (other than Medicaid coverage solely for pediatric vaccines), then you may change your election to begin or increase group healthcare coverage of that person.

Loss of Certain Governmental Healthcare Coverage
You may change your election to add group healthcare coverage for yourself, your spouse or your dependents if you or they lose group healthcare coverage sponsored by a governmental or educational institution, including a state children's health insurance program (CHIP) under Title XXI of the Social Security Act, certain Native American health insurance programs, a state health benefits risk pool or a foreign government group health plan. However, you may not drop group healthcare coverage during the year in favor of these governmental health programs. The information described above does not apply to your Health Care Flexible Spending Account.

Cost of Coverage
Regular deductions for your LifeTimes Benefit Choices occur with before-tax dollars. This means that you do not pay Social Security tax, federal income tax and most state taxes on the amount deducted for these coverages. In addition, HCA may also contribute to the cost of certain coverages.

Although the use of before-tax dollars reduces your taxable pay, benefits that are based on your pay — such as Life Insurance and Long-Term Disability (LTD) coverage — are not reduced. These benefits will continue to be based on your pay as determined by these plans.

You may be required to contribute for your coverage. Log on to LifeTimes Connection at HCArewards.com for your cost information.

When Coverage Begins
Generally, if you are eligible, your coverage begins on the first day of the month after you complete two calendar months of service, as long as you are actively at work on that day. (In some facilities, you may be eligible sooner. Log on to LifeTimes Connection at HCArewards.com or review your enrollment materials for your actual Benefit Effective Date.) You will be considered to be actively at work if your effective date falls on a non-scheduled weekday, weekend or holiday.

If you are away from work on your effective date because of a health status-related factor, your Medical, Dental and Health Care Flexible Spending Account (FSA) coverage will begin on the same day that it would have begun if you were actively at work. But Life Insurance and Long-Term Disability (LTD) coverage will not begin until you return to work for one full day.

Likewise, any days you are absent from work because of your own health status, medical condition or disability will still count toward your eligibility waiting period as if you had been actively at work, but only for Medical, Dental and Health Care FSA benefits.

Generally, your dependents' coverage begins on the same day your coverage begins. For Dependent Life Insurance, if your dependent is totally disabled on the date coverage should begin, it is delayed until the dependent is no longer totally disabled.

This delayed effective date rule also applies to any increase in LTD, your Life Insurance or Dependent Life Insurance coverage due to a change in annual pay, qualified change in status event or an annual enrollment election.

If evidence of insurability is required, Life Insurance and LTD coverage for you and your dependents will begin once the carrier approves the evidence of insurability. (Evidence of insurability may not be required when you first become eligible.)

Rehire
If you terminate employment and are rehired within six months, coverage will begin on the first day you return to work subject to the eligibility periods and delayed effective date rule. If you are rehired within six months within the same calendar year, your previous elections will be reinstated and no changes are allowed except for a qualifying change in status or special enrollment rights. You may not reinstate your Health Care Flexible Spending Account for the remainder of the calendar year.

However, if you are rehired in the following calendar year, your previous elections will apply (if the option is no longer available, default options (see page 13) apply). You will have 31 days from your rehire date to make changes, subject to evidence of insurability rules for life and long-term disability coverages. Any Flexible Spending Account elections will not be reinstated; you must make these elections within 31 days of your rehire date.

If you are rehired after 6 months, you are treated as a new hire.

When Coverage Ends

Medical, Dental and Life Insurance Coverage
Medical, Dental and Life Insurance coverage ends as shown in the following table. In certain circumstances, Medical, Dental and Health Care Flexible Spending Account coverage may be continued under COBRA.

If …	Coverage ends …
You stop working for your facility or retire	The last day of the month following your last day at work (not the last day you are paid)
You no longer meet the eligibility rules	The last day of the month
Your dependent no longer meets the eligibility rules	The date eligibility is lost. For example, your child's coverage ends on his or her 19th birthday (or 26th birthday if a student regularly attending an accredited school)
You stop coverage for yourself and/or your dependents because of a qualifying change in status	The date the qualifying change in status occurs. For example, your spouse's coverage would end at midnight on the date of the divorce
You choose to stop coverage for yourself and/or your dependents during the annual enrollment period	The last day of the current calendar year
HCA no longer provides the coverage	The last day the coverage is in effect
You don't make the required contributions	The end of the month in which premiums were paid
You are not at work due to disease, injury or approved paid or unpaid leave of absence and you stop making contributions	The last day before leave starts unless contributions continue. Benefits cannot continue longer than six months from the day you begin your paid or unpaid leave
You have continued coverage during a paid leave that continues beyond six months	The last day of the six months following the start of you leave of absence
You die	All coverage for you ends on the date of death; however, coverage for your covered dependents terminates at the end of the month

Removing Dependents from Coverage
It is your responsibility to call LifeTimes Connection at 1-800-566-4114 to remove ineligible dependents from coverage as soon as they become ineligible, or at least within 31 days of the date they become ineligible. Until you do so, you will continue to pay for coverage, but LifeTimes Benefit Choices may cancel coverage for that dependent immediately upon learning of the dependent’s ineligibility. LifeTimes Benefit Choices may make that cancellation effective to the date of ineligibility. Any amounts you pay for coverage for an ineligible dependent may not be refunded.

Aetna HMO Tennessee Coverage

Selecting a Participating Primary Care Physician

At the time of enrollment, each participant should select a participating primary care physician (PCP) from Aetna's Directory of participating providers to access covered benefits. The choice of a PCP is made solely by the participant. Until a PCP is selected, benefits will be limited to coverage for medical emergency care.

The Primary Care Physician

The PCP coordinates a participant's medical care, as appropriate, either by providing treatment or by issuing referrals to direct the participant to a participating provider. The PCP can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization. Except in a medical emergency or for certain direct access specialist benefits, only those services which are provided by; or referred by; a participant's PCP will be covered. Covered benefits are described in the Covered Benefits section. It is a participant's responsibility to consult with the PCP in all matters regarding the participant's medical care. If the participant's PCP performs; suggests; or recommends; a participant for a course of treatment that includes services that are not covered benefits, the entire cost of any such non-covered services will be the participant's responsibility.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular provider. Either Aetna or any participating provider may terminate the provider contract or limit the number of participants that will be accepted as patients. If the PCP initially selected cannot accept additional patients, the participant will be notified and given an opportunity to make another PCP selection. The participant must then cooperate with Aetna to select another PCP. Until a PCP is selected, benefits are limited to coverage for medical emergency care.

Changing a PCP

A participant may change the PCP at any time by calling the Aetna Member Services phone number listed on the participant's ID card or logging on to the Aetna Web site on the Benefit Providers page at HCArewards.com. The change will become effective upon Aetna's receipt and approval of the request.

Dependents Living Out of the Network Area

You and your covered dependents must use a network provider to receive maximum benefits. If a covered dependent, such as a college student, if living out of the network area, contact Aetna to determine if network providers are available in the area.

Ongoing Reviews

Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits. If Aetna determines that the recommended services and supplies are not covered benefits, the participant will be notified. If a participant wishes to appeal such determination, the participant may then contact Aetna to seek a review of the determination.

Authorization

Certain services and supplies may require authorization by Aetna to determine if they are covered benefits. Those services and supplies requiring Aetna authorization are indicated in the Covered Benefits section.

Covered Benefits

A participant shall be entitled to the covered benefits as specified below. Unless specifically stated otherwise, in order for benefits to be covered, they must be medically necessary. For the purpose of coverage, Aetna may determine whether any benefit provided is medically necessary, and Aetna has the option to only authorize coverage for a covered benefit performed by a particular provider. Preventive care, as described below, will be considered medically necessary.

To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the participant's overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well baby care, as determined by Aetna;
- Be a diagnostic procedure, indicated by the health status of the participant and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the participant's overall health condition;
- Include only those services and supplies that cannot be safely and satisfactorily provided at home; in a physician's office; on an outpatient basis; or in any facility other than a hospital; when used in relation to inpatient hospital services; and

- As to diagnosis; care; and treatment; be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests

In determining if a service or supply is medically necessary, Aetna's Patient Management Medical Director or its physician designee will consider:

- Information provided on the participant's health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis; care; or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which have credence but do not overrule contrary opinions; and any other relevant information brought to Aetna's attention.

All covered benefits will be covered in accordance with the guidelines determined by Aetna.

If a participant has questions regarding coverage, the participant may call the Member Services phone number listed on the participant's ID card.

The participant is responsible for payment of the applicable copayments listed on the schedule of benefits. Except for direct access, specialist benefits or in a medical emergency or urgent care situation, , the following benefits must be accessed through the PCP's office that is shown on the participant's identification card, or elsewhere upon prior referrals issued but the participant's PCP.

Primary Care Physician Benefits

- Office visits during office hours.
- Home visits.
- After-hours PCP services. PCP's are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a participant becomes sick or is injured after the PCP's regular office hours, the participant should:
    - Call the PCP's office; and
    - Identify himself or herself as a participant; and
    - Follow the PCP's or covering physician's instructions.

  If the participant's injury or illness is a medical emergency, the participant should follow the procedures outlined under the Emergency Care/Urgent Care Benefits section.
- Hospital visits.
- Periodic health evaluations to include:
    - Well child care from birth including immunizations and booster doses of all immunizing agents used in child immunizations which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services.
    - Routine physical examinations.
    - Routine gynecological examinations, including Pap smears, for routine care, administered by the PCP. Or the participant may also go directly to a participating gynecologist without a referrals for routine GYN examinations and Pap smears. See the Direct Access Specialist Benefits section for a description of these benefits.
    - Routine hearing screenings.
    - Immunizations (but not if solely for the purpose of travel or employment).
    - Routine vision screenings.
    - One annual medically necessary Chlamydia screening when performed in conjunction with a routine Pap smear for female participants not more than 29 years of age.
- Injections, including allergy desensitization injections.
- Casts and dressings.
- Health Education Counseling and Information.

Clinical Trials

Coverage will be provided for medically necessary and routine patient care physician and facility costs incurred by participants who are enrolled in a Phase I, Phase II, Phase III or Phase IV Clinical Trial study.

"Clinical Trial" means a patient research study that is designed to evaluate a new drug, medical device, or service that falls within a Medicare benefit category and is not statutorily excluded from coverage. Such proposed treatment:

- Must be intended to treat cancer;
- Must have therapeutic intent; and
- Must be recommended by the participant's participating physician as having meaningful potential benefit to the participant based upon at least two documents of medical and scientific evidence.

The clinical trial must meet the following criteria:

- It must involve a drug that is exempt under federal regulations from new drug application.
- It must be approved by centers or cooperative groups that are funded and sponsored by the National Institutes of Health, the Food and Drug Administration (FDA) in the form of an investigational new drug application, the Department of Defense, or the Department of Veterans Affairs.

Covered Benefits for:

- Healthcare services for the appropriate monitoring of the covered person during the clinical trial; and
- The treatment:
- Provided in the clinical trial; and
- That is a result of unintended medical complications caused by the treatment provided in the clinical trial; are payable on the same basis as any disease or illness covered under this Certificate.

Any care provided in the clinical trial must be for services that are considered covered benefits under this plan.

Participants are subject to all of the terms; conditions; provisions; limitations; and exclusions of this plan including, but not limited to any precertification and referral requirements.

- Any drug, device, or service that is not approved by the FDA and that is associated with the clinical trial; and
- Any expenses customarily paid by a government, or by a biotechnical, pharmaceutical or medical industry; and
- Costs of data collection and record-keeping that would not be required but for the Clinical Trial; and
- Any expenses for the management of research;
- Any expenses related to participation in the Clinical Trial, including travel, housing, and other expenses;
- Any expenses incurred by a person accompanying the covered person; and
- Any expenses related to determining eligibility for participation in the Clinical Trial; and
- Services and supplies provided “free of charge” by the Clinical Trial sponsor to the covered person.

The experimental and investigational procedures provision of the Exclusions and Limitations section of will not apply to covered benefits.

Diagnostic Services

Services include, but are not limited to, the following:

- Diagnostic; laboratory; and x-ray services.
- Mammograms, by a participating provider. The participant is required to obtain a referral from her PCP or Gynecologist, or obtain prior authorization from Aetna to a participating provider, prior to receiving this benefit. Screening mammogram benefits for female participants are provided as follows:
    - Age 35 to age 40, one baseline mammogram; and
    - Age 40 and older, one routine mammogram every year; or
    - When medically necessary.
- Bone mass measurement for a qualified participant for the diagnosis and treatment of osteoporosis. A qualified participant is a participant with a condition for which bone mass measurement is determined to be medically necessary by the participant’s physician.

Specialist Physician Benefits

Covered benefits include outpatient and inpatient services.

Direct Access Specialist Benefits

The following services are covered without a referral when rendered by a participating provider.

- Routine Gynecological Examination(s): Routine gynecological visit(s) and Pap smear(s). The number of visits, if any, is listed on the Schedule of Benefits.
- Open Access to Gynecologists: Benefits are provided to female participants for services performed by a participating gynecologist for diagnosis and treatment of gynecological problems. See the Infertility Services section for a description of Infertility benefits.
- Routine Eye Examinations, including refraction, as follows:
    - If participant is age 1 through 18 and wears eyeglasses or contact lenses, one exam every 12-month period.
    - If participant is age 19 and over and wears eyeglasses or contact lenses, one exam every 24-month period.
    - If participant is age 1 through 45 and does not wear eyeglasses or contact lenses, one exam every 36-month period.
    - If participant is age 46 and over and does not wear eyeglasses or contact lenses, one exam every 24-month period.

Maternity Care and Related Newborn Care
Outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by participating providers are a covered benefit. To be covered for these benefits, the participant must choose a participating obstetrician from Aetna's list of participating providers and inform Aetna by calling the Member Services phone number listed on the participant's ID card, prior to receiving services. The participating provider is responsible for obtaining prior authorization for all obstetrical care from Aetna after the first prenatal visit.

Coverage does not include routine maternity care (including delivery) received while outside the Service Area unless the participant receives prior authorization from Aetna. As with any other medical condition, emergency services are covered when medically necessary.

Inpatient Hospital & Skilled Nursing Facility Benefits
A participant is covered for services only at participating hospitals and participating skilled nursing facilities. All services are subject to preauthorization by Aetna. In the event that the participant elects to remain in the hospital or skilled nursing facility after the date that the participating provider and/or the Aetna Medical Director has determined and advised the participant that the participant no longer meets the criteria for continued inpatient confinement, the participant shall be fully responsible for direct payment to the hospital or skilled nursing facility for such additional hospital, skilled nursing facility, physician and other provider services, and Aetna shall not be financially responsible for such additional services.

As an exception to the medically necessary requirements, the following coverage is provided for a mother and newly born child:

- A minimum of 48 hours of inpatient care in a participating hospital following a vaginal delivery;
- A minimum of 96 hours of inpatient care in a participating hospital following a cesarean section; or
- A shorter hospital stay, if requested by a mother, and if determined to be medically appropriate by the participating providers in consultation with the mother. It shall be in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

If a participant requests a shorter hospital stay, the participant will be covered for one home healthcare visit scheduled to occur within 24 hours of discharge. An additional visit will be covered when prescribed by the participating provider. Such visits will be provided in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. This benefit is in addition to the home health maximum number of visits, if any, shown on the Schedule of Benefits. A copayment will not apply for home healthcare visits.

Coverage for skilled nursing facility benefits is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

Transplants
Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplants must be ordered by the participant's PCP and participating specialist physician and approved by Aetna's Medical Director in advance of the surgery. The transplant must be performed at hospitals specifically approved and designated by Aetna to perform these procedures. A transplant is non-experimental and non-investigational hereunder when Aetna has determined, in its sole discretion, that the medical community has generally accepted the procedure as appropriate treatment for the specific condition of the participant. Coverage for a transplant where a participant is the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program. Coverage includes treatment of breast cancer by chemotherapy and autologous bone marrow transplants or stem cell transplants.

Outpatient Surgery Benefits
Coverage is provided for outpatient surgical services and supplies in connection with a covered surgical procedure when furnished by a participating outpatient surgery center. All services and supplies are subject to preauthorization by Aetna.

Substance Abuse Benefits
A participant is covered for the following services as authorized and provided by participating behavioral health providers:

- Outpatient care benefits are covered for detoxification. Benefits include diagnosis, medical treatment and medical referral services (including referral services for appropriate ancillary services) by the participant's PCP for the abuse of or addiction to alcohol or drugs.

  Participant is entitled to outpatient visits to a participating behavioral health provider upon referrals by the PCP for diagnostic, medical or therapeutic rehabilitation services for substance abuse. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

- Inpatient care benefits are covered for detoxification. Benefits include medical treatment and referral services for substance abuse or addiction. The following services shall be covered under inpatient treatment: lodging and dietary services; physicians, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies.

  Participant is entitled to medical, nursing, counseling or therapeutic rehabilitation services in an inpatient, non-hospital residential facility, appropriately licensed by the Department of Health, upon referral by the participant's participating behavioral health provider for alcohol or drug abuse or dependency. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

Mental Health Benefits
A participant is covered for services for the treatment of the following mental or behavioral conditions through participating behavioral health providers.

- Outpatient benefits are covered for short-term outpatient evaluative and crisis intervention or home health mental health services, and is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

- Inpatient benefits may be covered for medical; nursing; counseling or therapeutic services in an inpatient, non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent. Coverage, if applicable, is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

- Inpatient benefit exchanges are a covered benefit. When authorized by Aetna, 1 mental health inpatient day, if any, may be exchanged for up to 4 outpatient or home health visits. This is limited to an exchange of up to a maximum of 10 inpatient days for a maximum of 40 additional outpatient visits. One inpatient day, if any, may be exchanged for two days of treatment in a partial hospitalization and/or outpatient electroshock therapy (ECT) program in lieu of hospitalization up to the maximum benefit limitation upon approval by Aetna.

- Requests for a benefit exchange must be initiated by the participant's participating behavioral health provider under the guidelines set forth by Aetna. Participant must utilize all outpatient mental health benefits, if any, available and pay all applicable copayments before an inpatient and outpatient visit exchange will be considered. The participant's participating behavioral health provider must demonstrate medical necessity for extended visits and be able to support the need for hospitalization if additional visits were not offered. Request for exchange must be approved in writing by Aetna prior to utilization.

Emergency Care/Urgent Care Benefits
A participant is covered for emergency services, provided the service is a covered benefit, and Aetna's review determines that a medical emergency existed at the time medical attention was sought by the participant.

The copayment for an emergency room visit as described in the Schedule of Benefits will not apply either in the event that the participant was referred for such visit by the participant's PCP for services that should have been rendered in the PCP's office or if the participant is admitted into the hospital.

The participant will be reimbursed for the cost for emergency services rendered by a nonparticipating provider located either within or outside the Aetna Service Area, for those expenses, less copayments, which are incurred up to the time the participant is determined by Aetna and the attending physician to be medically able to travel or to be transported to a participating provider. In the event that transportation is medically necessary, the participant will be reimbursed for the cost as determined by Aetna, minus any applicable copayments. Reimbursement may be subject to payment by the participant of all copayments which would have been required had similar benefits been provided during office hours and upon prior referrals to a participating provider.

Medical transportation is covered during a medical emergency.

Urgent Care Within the Aetna Service Area
If the participant needs urgent care while within the Aetna Service Area, but the participant's illness, injury or condition is not serious enough to be a medical emergency, the participant should first seek care through the participant's PCP. If the participant's PCP is not reasonably available to provide services for the participant, the participant may access urgent care from a participating urgent care facility within the Aetna Service Area.

Urgent Care Outside the Aetna Service Area
The participant will be covered for urgent care obtained from a physician or licensed facility outside of the Aetna Service Area if the participant is temporarily absent from the Aetna Service Area and receipt of the healthcare service cannot be delayed until the participant returns to the Aetna Service Area.

A participant is covered for any follow-up care. Follow-up care is any care directly related to the need for emergency care which is provided to a participant after the medical emergency care or urgent care situation has terminated. All follow-up and continuing care must be provided or arranged by a participant's PCP. The participant must follow this procedure, or the participant will be responsible for payment for all services received.

Rehabilitation Benefits

Inpatient and Outpatient Rehabilitation Benefits
The following benefits are covered by participating providers upon referrals issued by the participant's PCP and approved by Aetna in advance of treatment.

- Cardiac rehabilitation benefits are available as part of a participant's inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered when medically necessary following angioplasty; cardiovascular surgery; congestive heart failure; or myocardial infarction.
- Pulmonary rehabilitation benefits are available as part of a participant's inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered when medically necessary for the treatment of reversible pulmonary disease states.

Outpatient Rehabilitation Benefits
The following benefits are covered when rendered by participating providers upon referral issued by the participant's PCP and pre-authorized by Aetna.

- Cardiac and pulmonary rehabilitation benefits:
  - Cardiac rehabilitation benefits are available as part of a participant's inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered when medically necessary following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
  - Pulmonary rehabilitation benefits are available as part of a participant's inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered when medically necessary for the treatment of reversible pulmonary disease states.
- Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits: Coverage is subject to the limits, if any, shown on the Schedule of Benefits. For inpatient rehabilitation benefits for the services listed below, refer to the inpatient hospital and skilled nursing Facility benefits provision under the Covered Benefits section.
  - Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is coordinated with Aetna as part of a treatment plan intended to restore previous cognitive function.
  - Physical therapy is covered for non-chronic conditions and acute illnesses and injuries.
  - Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries.
  - Speech therapy is covered for non-chronic conditions and acute illnesses and injuries.

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

No coverage is provided for:

- Diagnostic or rehabilitative services rendered before the participant becomes eligible for coverage or after termination of coverage;
- Hearing aids; hearing aid evaluation tests; and hearing aid batteries;
- Hearing exams required as a condition of employment; and
- Special education for a participant whose ability to speak or hear is lost or impaired. This includes sign language.

Home Health Benefits
The following services are covered for a homebound participant when provided by a participating home healthcare agency. Pre-authorization must be obtained from Aetna by the participant's attending participating physician.

Aetna shall not be required to provide home health benefits when Aetna determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide covered healthcare services.

Coverage for home health services is not determined by the availability of caregivers to perform the services; the absence of a person to perform a non-skilled or custodial care service does not cause the service to become covered. If the participant is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the participant's non-skilled needs. Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

Skilled nursing services that require the medical training of and are provided by a licensed nursing professional are a covered benefit. Services must be provided during intermittent visits of four hours or less with a daily maximum of three visits. Up to 12 hours (three visits) of continuous skilled nursing services per day within 30 days of an inpatient hospital or skilled nursing facility discharge may be covered, when all home healthcare criteria are met, for transition from the hospital or skilled nursing facility to home care. Services are subject to the limits, if any, listed in the Outpatient Home Health Visits section of the Schedule of Benefits.

Services of a home health aide are covered only when they are provided in conjunction with skilled nursing services and directly support the skilled nursing. Services must be provided during intermittent visits of four hours or less with a daily maximum of three visits. Services are subject to the limits, if any, listed in the Outpatient Home Health Visits section of the Schedule of Benefits.

Medical social services are covered only when they are provided in conjunction with skilled nursing services and must be provided by a qualified social worker.

Outpatient home health short-term physical, speech, or occupational therapy is covered when the above home healthcare criteria are met. Coverage is subject to the conditions and limits listed in the Outpatient Rehabilitation Benefit section of this plan and the Outpatient Rehabilitation section of the Schedule of Benefits.

Hospice Benefits
Hospice care services for a terminally ill participant are covered when preauthorized by Aetna. Services may include: home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of a family participant; inpatient care; counseling and emotional support; and other home health benefits listed above.

Coverage is not provided for bereavement counseling; funeral arrangements; pastoral counseling; financial; or legal counseling. Homemaker or caretaker services and any service not solely related to the care of the participant, including but not limited to: sitter or companion services for the participant or other participants of the family; transportation; house cleaning; and maintenance of the house are not covered. Coverage is not provided for respite care.

Prosthetic Appliances
The participant's initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects is covered when such device is prescribed by a participating provider and authorized in advance by Aetna. Coverage includes repair and replacement when due to congenital growth. Instruction and appropriate services required for the participant to properly use the item (such as attachment or insertion) are covered.

Replacement prosthetic devices that temporarily or permanently replace all or part of an external body part lost or impaired as a result of disease; or injury; or congenital defects are covered, when such devices are prescribed by a participating provider and authorized in advance by Aetna. Coverage includes repair and replacement when due to congenital growth. Instruction and appropriate services required for the participant to properly use the item (such as attachment or insertion) are covered.

Injectable Medications
Injectable medications, except self-injectable drugs eligible for coverage under the Prescription Drug Section, are a covered benefit when an oral alternative drug is not available, unless specifically excluded as described in the Exclusions and Limitations section. Medications must be prescribed by a provider licensed to prescribe federal legend prescription drugs or medicines, and pre-authorized by Aetna. If the drug therapy treatment is approved for self-administration, the participant is required to obtain covered medications at an Aetna participating pharmacy designated to fill injectable prescriptions.

Injectable drugs or medication used for the treatment of cancer or HIV are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in 1 of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least 1 study published in a nationally recognized peer reviewed journal.

Infertility Services
Infertility services are covered upon prior authorization by Aetna when provided by a participating provider. Benefits include, but are not limited to, services to diagnose and treat the underlying medical cause of Infertility which are furnished to a participant.

Reconstructive Breast Surgery
Reconstructive breast surgery resulting from a mastectomy is covered. Coverage includes reconstruction of the breast on which the mastectomy is performed including aereolar reconstruction and the insertion of a breast implant; surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed; and medically necessary physical therapy to treat the complications of mastectomy, including lymphedema.

Subluxation Benefits
Services by a participating provider when medically necessary and upon prior referrals issued by the PCP. Services must be consistent with Aetna guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation which could be documented by diagnostic x-rays performed by an Aetna participating radiologist.

Treatment of Phenylketonuria
Coverage shall be provided for formula or dietary supplements prescribed by a physician for the treatment of Phenylketonuria.

Additional Benefits

Durable Medical Equipment Benefits
Durable medical equipment will be provided when preauthorized by Aetna. The wide variety of Durable medical equipment and continuing development of patient care equipment makes it impractical to provide a complete listing, therefore, the Aetna Medical Director has the authority to approve requests on a case-by-case basis. Covered durable medical equipment includes those items covered by Medicare unless excluded in the Exclusions and Limitations section. Aetna reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

Instruction and appropriate services required for the participant to properly use the item, such as attachment or insertion, is also covered upon preauthorization by Aetna. Replacement; repairs; and maintenance are covered only if it is demonstrated to Aetna that:

- It is needed due to a change in the participant's physical condition; or
- It is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

All maintenance and repairs that result from a misuse or abuse are a participant's responsibility.

A copayment, a maximum annual out-of-pocket payment, and a maximum annual benefit may apply to this service. Refer to the Schedule of Benefits.

Diabetic Supplies and Equipment
Subject to payment of the applicable copayment, the following equipment, supplies and education services for the treatment of insulin treated diabetes, non-insulin treated diabetes, and gestational diabetes conditions are covered when medically necessary and when prescribed or ordered by a participating primary care physician (or participating nurse practitioner or clinical nurse specialist) and obtained through a participating provider: blood glucose monitors and blood glucose monitors for the legally blind, test strips for glucose monitors; visual reading and urine test strips, insulin, injection aids, syringes, lancets, insulin pumps, infusion devices, and appurtenances thereto, oral hypoglycemic agents, podiatric appliances for prevention of complications associated with diabetes; and Glucagon emergency kits.

When test strips for blood glucose monitors are prescribed by a physician as medically necessary for a non-insulin using participant with diabetes, the coverage shall be limited to twelve (12) bottles of fifty (50) test strips per bottle, per calendar year, unless Aetna approves a larger quantity of test strips based upon a determination by Aetna that a larger quantity is medically necessary for the participant.

Coverage also includes diabetes outpatient self-management training and education services, including medical nutrition counseling, when prescribed by a physician as medically necessary for the treatment of diabetes, to ensure that participants with diabetes are instructed as to the proper self-management and treatment of their diabetic condition, including information on the nutritional management of diabetes. Such coverage for self-management education and education relating to medical nutrition therapy shall be limited to visits medically necessary upon the diagnosis of diabetes or where a participating primary care physician (or participating nurse practitioner or clinical nurse specialist) diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a participant's self-management, or where reeducation or refresher education is necessary. Such education, when medically necessary and prescribed by a participating primary care physician, must be provided only by a participating primary care physician or upon referral to an appropriately licensed and certified healthcare provider and may be conducted in group settings registered by a nationally recognized professional association of dietitians or a health professional recognized by the American Council on Pharmaceutical Education and the Tennessee Board of Pharmacy, or other healthcare professionals licensed in the State of Tennessee that have expertise in diabetes

management as determined by Aetna. Coverage for self-management education and education relating to medical nutrition therapy shall also include home visits when medically necessary. Participant will be responsible for the pharmacy copayment.

Self-injectable Drugs
Self-injectable drugs, eligible for coverage under this plan, are covered when prescribed by a provider licensed to prescribe federal legend prescription drugs or medicines. The initial prescription must be filled at a participating retail pharmacy, participating mail order pharmacy or specialty pharmacy network pharmacy. All refills must be filled by a participating mail order pharmacy or specialty pharmacy network pharmacy. Coverage of self-injectable drugs may, in Aetna's sole discretion, be subject to the Precertification Program, the Step Therapy Program or other Aetna requirements or limitations. Food and Drug Administration (FDA) approved self-injectable drugs, eligible for coverage under this plan, are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in Aetna's sole discretion, be subject to the Precertification Program, the Step Therapy Program or other HMO requirements or limitations. Participant is responsible for the payment of the applicable copayment for each prescription or refill. The copayment is specified in the Prescription Drug section.

Aetna HMO Tennessee Schedule of Benefits

Out-of-Pocket Maximum (Individual / Family)	$2,000 / $4,000
Outpatient Benefits:	**You Pay:**
Primary Care Physician Services:	
Adult Physical Examination	$15 per visit
Well Child Physical Examination including Immunizations	$15 per visit
Office Hours Visits	$15 per visit
After-Office Hours and Home Visits	$15 per visit
Routine Gynecological Exam(s): 1 visit per 365 days	$15 per visit
Specialist Physician Services Office Visit:	$15 per visit
First Prenatal Visit	$15
Outpatient Rehabilitation: Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment	$15 per visit
Outpatient Facility Visits	$15 per visit
Diagnostic X-Ray Testing	$15 per visit
Mammography	$15 per visit
Diagnostic Laboratory Testing	$15 per visit
Outpatient Emergency Services: Hospital emergency room or outpatient department	$100 per visit
Urgent Care Facility	$50 per visit
Ambulance	$0 per trip
Outpatient Mental Health Visits: 30 visits per plan year	$15 per visit
Outpatient Substance Abuse Visits: 30 visits per plan year	$15 per visit/day
Outpatient Surgery: Performed at a participating hospital outpatient facility when the facility is located in the Nashville Aetna Service Area and is not an HCA-affiliated facility.	$500 per visit
Outpatient Home Health Visits: Limited to 3 intermittent visit(s) per day provided by a participating home healthcare agency; 1 visit equals a period of 4 hours or less, Unlimited visits per calendar year	$0
Outpatient Hospice Care Visits	$0
Injectable Medications	$15 per visit or per prescription or refill

Inpatient Benefits:	You Pay:
Acute Care	• $250 per admission for HCA-affiliated Network Facility • $500 per admission for Aetna In-Network Facility
Mental Health: Maximum of 30 days per calendar year	• $250 per admission for HCA-affiliated Network Facility • $500 per admission for Aetna In-Network Facility
Substance Abuse:	
Rehabilitation: Maximum of 30 days per calendar year	• $250 per admission for HCA-affiliated Network Facility • $500 per admission for Aetna In-Network Facility
Detoxification	• $250 per admission for HCA-affiliated Network Facility • $500 per admission for Aetna In-Network Facility
Maternity	• $250 per admission for HCA-affiliated Network Facility • $500 per admission for Aetna In-Network Facility
Skilled Nursing Facility: Maximum of 100 days per calendar year	• $250 per admission for HCA-affiliated Network Facility • $500 per admission for Aetna In-Network Facility (waived if a participant is transferred from a hospital to a skilled nursing facility)
Hospice Care	• $250 per admission for HCA-affiliated Network Facility • $500 per admission for Aetna In-Network Facility (waived if a participant is transferred from a hospital to a Hospice Care Facility)
Morbid Obesity Surgery	Not covered
Additional Benefits:	**You Pay:**
Eye Examination: By a specialist (including refraction) as per schedule in the plan	$15 per visit
Subluxation: 20 visits per plan year	$15 per visit
Durable Medical Equipment (DME)	20% (of the cost) per item
DME Maximum Benefit	Unlimited per participant, per plan year

Exclusions and Limitations

Exclusions
The following are not covered benefits except as described in the Covered Benefits section:

- Ambulance services, for routine transportation to receive outpatient or inpatient services.
- Beam neurologic testing.
- Biofeedback, except as specifically approved by Aetna.
- Blood and blood plasma, including but not limited to: provision of blood; blood plasma; blood derivatives; synthetic blood or blood products other than blood derived clotting factors; the collection or storage of blood plasma; the cost of receiving the services of professional blood donors; apheresis; or plasmapheresis. Only administration; processing of blood; processing fees; and fees related to autologous blood donations are covered.
- Care for conditions that state or local law require to be treated in a public facility, including but not limited to: mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic Surgery or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, other than medically necessary services. This exclusion includes, but is not limited to: surgery to correct gynecomastia and breast augmentation procedures; and otoplasties. Reduction mammoplasty, except when determined to be medically necessary by an Aetna Medical Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to: cleft lip and cleft palate. This exclusion does not apply to reconstructive breast surgery resulting from a mastectomy.
- Costs for services resulting from the commission or attempt to commit a felony by the participant.
- Court ordered services, or those required by court order as a condition of parole or probation.

- Custodial Care.
- Dental services, including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, prosthetic restoration of dental implants, and dental implants. This exclusion does not include bony impacted teeth, bone fractures, removal of tumors, and orthodontogenic cysts. In addition, this exclusion does not apply to anesthesia or hospital services performed for an inpatient or outpatient dental procedure on a minor, 8 years of age or younger, when the procedure could not be performed safely in a dental office setting.
- Educational services and treatment of behavioral disorders, together with services for remedial education including: evaluation or treatment of learning disabilities; minimal brain dysfunction; developmental and learning disorders; behavioral training; and cognitive rehabilitation. This includes services, treatment or educational testing and training related to: behavioral (conduct) problems; learning disabilities; or developmental delays. Special education, including lessons in sign language to instruct a participant, whose ability to speak has been lost or impaired, to function without that ability, are not covered.
- Experimental or Investigational Procedures or ineffective: surgical; medical; psychiatric; or dental treatments or procedures; research studies; or other experimental or investigational healthcare procedures; or pharmacological regimes as determined by Aetna, unless approved by Aetna prior to the treatment being rendered.
  This exclusion will not apply with respect to drugs:
    - That have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
    - That are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
    - Aetna has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.
- False teeth.
- Hair analysis.
- Health services, including those related to pregnancy, rendered before the effective date or after the termination of the participant's coverage, unless coverage is continued under the Continuation and Conversion section.
- Hearing aids.
- Household equipment, including but not limited to: the purchase or rental of exercise cycles; water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a participant's house or place of business, and adjustments made to vehicles.
- Hypnotherapy, except when specifically approved by Aetna.
- Implantable drugs.
- Infertility services, including: the treatment of male and female Infertility; injectable Infertility drugs; charges for the freezing and storage of cryopreserved embryos; charges for storage of sperm; and donor costs, including but not limited to: the cost of donor eggs and donor sperm; the costs for ovulation predictor kits; and the costs for donor egg program; or gestational carriers.
- Injectable drugs, except for insulin and self-injectable drugs. Coverage is subject to the terms and conditions of the plan.
- Military service related diseases, disabilities or injuries for which the participant is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the participant.
- Missed appointment charges, including any charge incurred for a missed appointment with a participating provider.
- Non-medically necessary services, including but not limited to: those services and supplies:
    - Which are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
    - That do not require the technical skills of a medical, mental health or a dentalprofessional;
    - Furnished mainly for the personal comfort or convenience of the participant, or any person who cares for the participant, or any person who is part of the participant's family, or any provider;
    - Furnished solely because the participant is an inpatient on any day in which the participant's disease or injury could safely and adequately be diagnosed or treated while not confined;
    - Furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.
- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics.
- Outpatient prescription or non-prescription drugs and medicines.
- Outpatient supplies, including but not limited to: outpatient medical consumable; or disposable supplies such as: syringes; incontinence pads; elastic stockings; and reagentstrips.

- Payment for benefits for which Medicare or a third party payer is the primary payer.
- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as: guest meals and accommodations; barber services; telephone charges; radio and television rentals; homemaker services; travel expenses; take-home supplies; and other like items and services.
- Private Duty Nursing (See the Home Health Benefits section regarding coverage of nursing services).
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational; educational; and sleep therapy; including any related diagnostic testing.
- Religious; marital; and sex counseling; including services and treatment related to religious counseling; marital/relationship counseling; and sex therapy.
- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.
- Routine foot/hand care, including routine reduction of nails; calluses; and corns.
- Services for which a participant is not legally obligated to pay in the absence of this coverage.
- Services for the treatment of sexual dysfunctions or inadequacies, including therapy; supplies; or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Services performed by a relative of a participant for which, in the absence of any health benefits coverage, no charge would be made.
- Services required by third parties, including but not limited to: physical examinations; diagnostic services and immunizations in connection with obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state, or federal government; securing insurance coverage; travel; school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.
- Services which are not a covered benefit, even when a prior referrals has been issued by a PCP.
- Specific non-standard allergy services and supplies, including but not limited to: skin titration (wrinkle method); cytotoxicity testing (Bryan's Test); treatment of non-specific candida sensitivity; and urine autoinjections.
- Specific injectable drugs, including:
    - Experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH);
    - Needles, syringes and other injectable aids;
    - Drugs related to the treatment of non-covered services; and
    - Drugs related to the treatment of Infertility, contraception, and performance enhancing steroids.
- Special medical reports, including those not directly related to treatment of the participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- Therapy or rehabilitation, including but not limited to: primal therapy; chelation therapy; rolfing; psychodrama; megavitamin therapy; purging; bioenergetic therapy; vision perception training; and carbon dioxide.
- Thermograms and thermography.
- Transsexual surgery; sex change or transformation; including any procedure or treatment or related service designed to alter a participant's physical characteristics from the participant's biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal; state; or governmental entity; including care and treatment provided in a non-participating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment of mental retardation; defects; and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded participants in accordance with the benefits provided in the Covered Benefits section.
- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. However, if proof is furnished to Aetna that the participant is covered under a workers' compensation law or similar law, but is not covered for a particular disease or injury under such law, that disease or injury will be considered "nonoccupational" regardless of cause.
- Unauthorized services, including any service obtained by or on behalf of a participant without prior referrals issued by the participant's PCP or certified by Aetna. This exclusion does not apply in a medical emergency, in an urgent care situation, or when it is a direct access benefit.
- Vision care services and supplies.
- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Family planning services.
- Temporomandibular joint disorder treatment (TMJ) including treatment performed byprosthesis placed directly on the teeth.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight

or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

- Any drug which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug) or for which an equivalent over-the-counter product in strength, is available even when a prescription is written, unless otherwise covered by Aetna.
- Any drug determined not to be medically necessary for the treatment of disease or injury unless otherwise covered under this plan.
- Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by Aetna.
- Cosmetic or any drugs used for cosmetic purposes or to promote hair growth, including but not limited to health and beauty aids.
- Needles and syringes, excluding diabetic needles and syringes.
- Any medication which is consumed or administered at the place where it is dispensed, or while a participant is in a hospital, or similar facility; or take home prescriptions dispensed from a hospital pharmacy upon discharge, unless the pharmacy is a participating retail or mail order pharmacy.
- Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
- Drugs used for the purpose of weight reduction (e.g., appetite suppressants), including the treatment of obesity.
- Any refill in excess of the amount specified by the prescription order. Before recognizing charges, Aetna may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.
- Any refill dispensed more than 1 year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.
- Drugs prescribed for uses other than uses approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations, or any drug labeled “Caution: Limited by Federal Law to Investigational Use”, or experimental drugs except as otherwise covered under this plan.
- Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use.
- Test agents and devices, excluding diabetic test agents.
- Injectable drugs used for the purpose of treating Infertility, unless otherwise covered by Aetna.
- Injectable drugs, except for insulin.
- Oral and implantable contraceptives and contraceptive devices, unless otherwise covered under this plan.
- Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this plan.
- Replacement for lost or stolen prescriptions.
- Performance, athletic performance or lifestyle enhancement drugs and supplies.
- Drugs and supplies when not indicated or prescribed for a medical condition as determined by Aetna or otherwise specifically covered under this plan or the medical plan.
- Drugs dispensed by other than a participating retail or mail order pharmacy, except as medically necessary for treatment of an emergency or urgent care condition.
- Medication packaged in unit dose form. (Except those products approved for payment by Aetna).
- Prophylactic drugs for travel.
- Drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee unless approved by Aetna through the medical exceptions process
- Drugs for the convenience of participants or for preventive purposes.
- Drugs listed on the Formulary Exclusions List unless otherwise covered through a medical exception as described or unless otherwise covered under this plan.
- Sildenafil citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Any prescription drug in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identicaloutcomes unless otherwise covered under this plan.
- Nutritional supplements.
- Smoking cessation drugs, except Chantix
- Growth hormones.

Limitations

- A participating retail or mail order pharmacy may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.
- Non-emergency and non-urgent care prescriptions will be covered only when filled at a participating retail pharmacy or the participating mail order pharmacy. Participants are required to present their ID card at the time the prescription is filled. A participant who fails to verify coverage by presenting the ID card will not be entitled to direct reimbursement from Aetna, and participant will be responsible for the entire cost of the prescription. Aetna will not reimburse participants for out-of-pocket expenses for prescriptions purchased from a participating retail pharmacy; participating mail order pharmacy or a non-participating retail or mail order pharmacy in non-emergency, non-urgent

care situations. Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Administration section.
- Participant will be charged the non-formulary prescription drug copayment for prescription drugs covered on an exception basis.

In the event there are two or more alternative medical services which in the sole judgment of Aetna are equivalent in quality of care, Aetna reserves the right to provide coverage only for the least costly medical service, as determined by Aetna, provided that Aetna approves coverage for the medical service or treatment in advance.

Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms are at the sole discretion of Aetna, subject to the terms in the Eligibility section.

Determinations regarding denial of benefits due to inappropriate use of the HMO Network are at the sole discretion of Aetna.

Prescription Drug Benefits

Outpatient Prescription Drug Open Formulary Benefit
Medically necessary outpatient prescription drugs and insulin are covered when prescribed by a provider licensed to prescribe federal legend prescription drugs or medicines subject to the terms, Aetna policies, Exclusions and Limitations section. Coverage is based on Aetna's or an affiliate's determination, in its sole discretion, if a prescription drug is covered. Some items are covered only with pre-authorization from Aetna. Items covered are subject to drug utilization review by Aetna and/or participant's participating provider and/or participant's participating retail or mail order pharmacy.

Each prescription is limited to a maximum 30-day supply when filled at a participating retail pharmacy or 90-day supply when filled by the participating mail order pharmacy designated by Aetna. Except in an emergency or urgent care situation, or when the participant is traveling outside the Aetna Service Area, prescriptions must be filled at a participating retail or mail order pharmacy. Coverage of prescription drugs may, in Aetna's sole discretion, be subject to the Precertification Program, the Step Therapy Program, or other HMO requirements or limitations.

FDA-approved prescription drugs are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information), or the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal. Coverage of off label use of these drugs may, in Aetna's sole discretion, be subject to the Precertification Program, the Step Therapy Program or other HMO requirements or limitations.

Emergency Prescriptions
Emergency prescriptions are covered subject to the following terms:
- When a participant needs a prescription filled in an emergency or urgent care situation, or when the participant is traveling outside of the Aetna Service Area, Aetna will reimburse the participant as described below.
- When a participant obtains an emergency or out-of-area urgent care prescription at a non-participating retail pharmacy, participant must directly pay the pharmacy in full for the cost of the prescription. Participant is responsible for submitting a request for reimbursement in writing to Aetna with a receipt for the cost of the prescription. Reimbursement requests are subject to professional review by Aetna to determine if the event meets Aetna's requirements. Upon approval of the claim, Aetna will directly reimburse the participant 100% of the cost of the prescription, less the applicable copayment specified below and any brand name prescription drug cost differentials as applicable. Coverage for items obtained from a non-participating pharmacy is limited to items obtained in connection with covered emergency and out-of-area urgent care services. Participants must access a participating retail pharmacy for urgent care prescriptions inside the Aetna Service Area.
- When a participant obtains an emergency or urgent care prescription at any participating retail pharmacy, including an out-of-area participating retail pharmacy, participant will pay to the participating retail pharmacy the copayment(s), plus the brand name prescription drug cost differentials where applicable and as described below. Participants are required to present their ID card at the time the prescription is filled. Aetna will not cover claims submitted as a direct reimbursement request from a participant for a prescription purchased at a participating retail pharmacy except upon professional review and approval by Aetna in its sole discretion. Participants must access a participating retail pharmacy for urgent care prescriptions inside the Aetna Service Area.

Mail Order Prescription Drugs
Subject to the terms and limitations set forth in this plan, medically necessary outpatient prescription drugs are covered when dispensed by the participating mail order pharmacy designated by Aetna and when prescribed by a provider licensed to prescribe federal legend prescription drugs. Outpatient prescription drugs will not be covered if dispensed by a participating mail order pharmacy in quantities that are less than a 30-day supply or more than a 90-day supply (if the provider prescribes such amounts).

Diabetic Supplies
The following diabetic supplies are covered if medically necessary upon prescription or upon participating physician's order only at a participating retail or mail order pharmacy, the participant must pay applicable copayments as described in the Copayments section below.

- Diabetic needles/syringes.
- Test strips for glucose monitoring and/or visual reading.
- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

Copayments
Participant is responsible for the copayments specified. The copayment, if any, is payable directly to the participating retail or mail order pharmacy for each prescription or refill at the time the prescription or refill is dispensed. If the participant obtains more than a 30-day supply of prescription drugs or medicines at the participating mail order pharmacy, not to exceed a 90-day supply, three copayments are payable for each supply dispensed. The copayment does not apply to the maximum out-of-pocket limit shown in the Schedule of Benefits for the medical plan, if any.

Prescription Drug/ Medicine Quantity	Generic Formulary Prescription Drugs	Brand Name Formulary Prescription Drugs	Non-Formulary Prescription Drugs
Less than a 31-day supply	$10	$20	$35

Prescription Drug Benefits Exclusions and Limitations

Exclusions
Unless specifically covered under this plan, the following are not covered:

1. Any drug which does not, by federal or state law, require a prescription order (i.e., an over-the-counter (OTC) drug) or for which an equivalent over-the-counter product in strength, is available even when a prescription is written, unless otherwise covered by Aetna.
2. Any drug determined not to be medically necessary for the treatment of disease or injury unless otherwise covered under this plan.
3. Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by Aetna.
4. Cosmetic or any drugs used for cosmetic purposes or to promote hair growth, including but not limited to health and beauty aids.
5. Needles and syringes, excluding diabetic needles and syringes.
6. Any medication which is consumed or administered at the place where it is dispensed, or while a participant is in a hospital, or similar facility; or take home prescriptions dispensed from a hospital pharmacy upon discharge, unless the pharmacy is a participating retail or mail order pharmacy.
7. Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
8. Drugs used for the purpose of weight reduction (e.g., appetite suppressants), including the treatment of obesity.
9. Any refill in excess of the amount specified by the prescription order. Before recognizing charges, Aetna may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.
10. Any refill dispensed more than one year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.
11. Drugs prescribed for uses other than uses approved by the Food and Drug Administration (FDA) under the Federal Food, Drug and Cosmetic Law and regulations, or any drug labeled "Caution: Limited by Federal Law to Investigational Use", or experimental drugs except as otherwise covered under this plan.
12. Medical supplies, devices and equipment and non-medical supplies or substances regardless of their intended use
13. Test agents and devices, excluding diabetic test agents
14. Injectable drugs used for the purpose of treating Infertility, unless otherwise covered by HMO.
15. Injectable drugs, except for insulin and self-injectable drugs
16. Oral and implantable contraceptives and contraceptive devices, unless otherwise covered under this plan.
17. Prescription orders filled prior to the effective date or after the termination date of the coverage provided by this plan.
18. Replacement for lost or stolen prescriptions.
19. Performance, athletic performance or lifestyle enhancement drugs and supplies.
20. Drugs and supplies when not indicated or prescribed for a medical condition as determined by Aetna or otherwise specifically covered under this plan.
21. Drugs dispensed by other than a participating retail or mail order pharmacy, except as medically necessary for treatment of an emergency or urgent care condition.
22. Medication packaged in unit dose form. (Except those products approved for payment by Aetna).
23. Prophylactic drugs for travel.

24. Drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee unless approved by Aetna through the medical exceptions process.
25. Drugs for the convenience of participants or for preventive purposes.
26. Drugs listed on the formulary exclusions list unless otherwise covered through a medical exception as described in this plan or unless otherwise covered under this plan.
27. Sildenafil citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Any prescription drug in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes unless otherwise covered under this plan.
28. Nutritional supplements.
29. Smoking cessation aids or drugs.
30. Growth hormones.

Limitations

1. A participating retail or mail order pharmacy may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.
2. Non-emergency and non-urgent care prescriptions will be covered only when filled at a participating retail pharmacy or the participating mail order pharmacy. Participants are required to present their ID card at the time the prescription is filled. A participant who fails to verify coverage by presenting the ID card will not be entitled to direct reimbursement from Aetna, and participant will be responsible for the entire cost of the prescription. Refer to the plan for a description of emergency and urgent Care coverage. Aetna will not reimburse participants for out-of-pocket expenses for prescriptions purchased from a participating retail pharmacy; participating mail order pharmacy or a non-participating retail or mail order pharmacy in non-emergency, non-urgent care situations. Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Appeals section.
3. Participant will be charged the non-formulary prescription drug copayment for prescription drugs covered on an exception basis.
4. The conversion privilege does not apply to the Aetna Prescription Plan.

Coordination of Benefits

Some participants have health coverage in addition to this coverage. When this is the case, the benefits paid by other plans will be taken into account. This may mean a reduction in benefits payable under this plan.
When coverage under this plan and coverage under another plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

- A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
- A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
    - Secondary to the plan covering the person as a dependent; and
    - Primary to the plan covering the person as other than a dependent;

  The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:
    - Covers the person as other than a dependent; and
    - Is secondary to Medicare.
- Except in the case of a dependent child whose parents are divorced or separated, the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time. If the other plan does not have the rule described in this provision, but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- In the case of a dependent child whose parents are divorced or separated:
    - If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the healthcare expenses of the child, the order of benefit determination rules specified in the provision above will apply.
    - If there is a court decree which makes one parent financially responsible for the medical, dental or other healthcare expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
    - If there is not such a court decree:
      If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

- If all of the above provisions above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:
  The benefits of a plan which covers the person as a:
  - Laid-off or retired employee; or
  - The dependent of such person;

  Shall be determined after the benefits of any other plan which covers such person as:
  - An employee who is not laid-off or retired; or
  - A dependent of such person.

  If the other plan does not have a provision:
  - Regarding laid-off or retired employees; and
  - As a result, each plan determines its benefits after the other, then the above paragraph will not apply.

  The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:
- Regarding right of continuation pursuant to federal or state law; and
- As a result, each plan determines its benefits after the other,

Then the above paragraph will not apply.

Aetna has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

Other plan means any other plan of health expense coverage under:
- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault and traditional “fault” auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Payment of Benefits
The combined benefits paid will not be more than the expenses recognized under the plans. In a calendar year, Aetna will pay its regular benefits in full, or a reduced benefit. The reduced amount will be 100% of Allowable Expenses less the benefits payable by the other plans. If the plan provides benefits in the form of services rather than cash payment, the cash value will be used. When this provision operates to reduce the total amount of benefits otherwise payable as to a participant covered during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately.

Such reduced amount will be charged against any applicable benefit limit of this coverage. The difference between the cost of a private hospital room and the semiprivate rate is not considered an Allowable Expense unless the patient's stay in a private hospital room is medically necessary, either in terms of generally accepted medical practice or as specifically defined.

Facility of Payment
A payment made by another plan may include an amount which should have been paid. If it does, Aetna may pay that amount to the plan that made that payment. That amount will then be treated as though it were a benefit paid by Aetna. Aetna will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Recovery of Overpayments
If the benefits paid under this plan, plus the benefits paid by other plans, exceeds the total amount of Allowable Expenses, Aetna has the right to recover the amount of that excess payment if it is the Secondary Plan, from among one or more of the following:
- Any person to or for whom such payments were made;
- Other plans;
- Any other entity to which such payments were made.

This right of recovery shall be exercised at Aetna's discretion. A participant shall execute any documents and cooperate with Aetna to secure its right to recover such overpayments, upon request from Aetna.

Medicare and Other Federal or State Government Programs

The provisions of this section will apply to the maximum extent permitted by federal or state law. Aetna will not reduce the benefits due any participant due to that participant's eligibility for Medicare where federal law requires that Aetna determines its benefits for that participant without regard to the benefits available under Medicare.

The coverage is not intended to duplicate any benefits for which participants are, or could be, eligible for under Medicare or any other federal or state government programs (such as Workers' Compensation). All sums payable under such programs for services provided shall be payable to and retained by Aetna. Each participant shall complete and submit to Aetna such consents, releases, assignments and other documents as may be requested by Aetna in order to obtain or assure reimbursement under Medicare or any other government programs for which participants are eligible. A participant is eligible for Medicare any time the participant is covered under it. Participants are considered to be eligible for Medicare or other government programs if they:

- Are covered under a program;
- Have refused to be covered under a program for which they are eligible;
- Have terminated coverage under a program; or
- Have failed to make proper request for coverage under a program.

Active Employees and Their Dependents Who Are Eligible For Medicare

Certain rules apply to active employees and their dependents who are eligible for Medicare. When a active participant, or the dependent of a active participant, is eligible for Medicare and the participant or dependent belongs to a group covered by the plan with 20 or more employees, that participant must make a written election to HCA indicating whom that participant wants to be his primary carrier. If the participant elects HCA's group plan as the primary plan, the plan will be the primary payer. If the participant elects Medicare as the primary plan, all benefits otherwise payable to that participant shall terminate. If the participant belongs to a covered group of less than 20 employees, the plan will be secondary payer and all benefits otherwise payable with respect to the participant will be paid in accordance with the Provision for Coordination with Medicare section below.

Covered Persons Who Are Disabled or Who Have End Stage Renal Disease (ESRD)

Special rules apply to participants who are disabled or who have End Stage Renal Disease. This plan will make primary and secondary payer determination in accordance with the Omnibus Budget Reconciliation Act (OBRA), as amended.

Provision for Coordination with Medicare

Aetna reserves the right to cover full benefits or to reduce benefits for any medical expenses covered under this plan. The amount Aetna will pay will be figured so that the amount, plus the benefits under Medicare, will equal no more than 100% of plan expenses. Plan expenses means any necessary medical expenses and reasonable charges, part or all of which are covered under Aetna. Charges for services used to satisfy a participant's Medicare Part B deductible will be applied under this plan in the order received by Aetna. Two or more charges for services received at the same time will be applied starting with the largest first. Any rules for Coordination of Benefits, as outlined, will be applied after Aetna's benefits have been calculated under the rules in this section. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Subrogation and Right of Reimbursement

As used herein, the term "Third Party" means any party that is, or may be, or is claimed to be responsible for injuries or illness to a participant. Such injuries or illness are referred to as "Third Party injuries." "Responsible Party" includes any parties actually, possibly or potentially responsible for payment of expenses associated with the care or treatment of Third Party injuries.

If this plan provides benefits to a participant for expenses incurred due to third party injuries, then Aetna retains the right to repayment of the full cost of all benefits provided by this plan on behalf of the participant that are associated with the third party injuries. Aetna's rights of recovery apply to any recoveries made by or on behalf of the participant from the following sources, including but not limited to: payments made by a third party or any insurance company on behalf of the third party; any payments or awards under an uninsured or underinsured motorist coverage policy; any workers' compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate a participant for medical expenses arising from third party injuries.

By accepting benefits under this plan, the participant specifically acknowledges Aetna's right of subrogation. When this plan provides healthcare benefits for expenses incurred due to third party injuries, Aetna shall be subrogated to the participant's rights of recovery against any party to the extent of the full cost of all benefits provided by this plan. Aetna will notify the participant or the participant's representative of its interest and maintain contact throughout the process.

By accepting benefits under this plan, the participant also specifically acknowledges Aetna's right of reimbursement. This right of reimbursement attaches when this plan has provided healthcare benefits for expenses incurred due to third party

injuries and the participant or the participant's representative has recovered any amounts from the following sources, including but not limited to: payments made by a third party or any insurance company on behalf of the third party; any payments or awards under an uninsured or underinsured motorist coverage policy; any workers' compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; and any other payments from a source intended to compensate a participant for medical expenses arising from third party injuries. By providing any benefit under this plan, Aetna is granted an assignment of the proceeds of any settlement, judgment or other payment received by the participant to the extent of the full cost of all benefits provided by this plan.

Aetna's right of reimbursement is cumulative with and not exclusive of Aetna's subrogation right and Aetna may choose to exercise either or both rights of recovery. Aetna may exercise its rights of reimbursement when the amounts received by the Aetna through a third party settlement or satisfied judgment are specifically identified in the settlement or judgment as the amounts previously paid by Aetna for the same medical services and benefits. Aetna will notify the participant or the participant's representative of its interest and maintain contact throughout the process.

By accepting benefits under this plan, the participant and the participant's representatives further agree to:

- Notify Aetna promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to third party injuries sustained by the Aetna;
- Cooperate with Aetna, provide Aetna with requested information, and do whatever is necessary to secure Aetna's rights of subrogation and reimbursement under this plan;
- Give Aetna a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with Third Party injuries provided by this plan;
- Pay, as the first priority, from any recovery, settlement, judgment, or other source of compensation for medical expenses arising from any and all amounts due Aetna as reimbursement for the full cost of all benefits associated with third party injuries provided by this plan (regardless of whether such payment will result in a recovery to the participant which is insufficient to make the participant whole or to compensate the participant in part or in whole for the damages sustained), unless otherwise agreed to by Aetna in writing; and
- Do nothing to prejudice Aetna's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by this plan.
- Serve as a constructive trustee for the benefit of this plan over any settlement or recovery funds received as a result of third party injuries.

Aetna may recover the full cost of all benefits provided by this plan without regard to any claim of fault on the part of the participant, whether by comparative negligence or otherwise.

No court costs or attorney fees may be deducted from Aetna's recovery, and Aetna is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by the participant to pursue the participant's claim or lawsuit against any responsible party without the prior express written consent of Aetna.

Recovery Rights Related to Worker's Compensation

If benefits are provided by Aetna for illness or injuries to a participant and Aetna determines the participant received workers' compensation benefits for the same incident that resulted in the illness or injuries, Aetna has the right to recover as described under the Subrogation and Right of Recovery provision.

"Workers' Compensation benefits" includes benefits paid in connection with a workers' compensation claim, whether paid by an employer directly, a workers' compensation insurance carrier, or any fun designed to provide compensation for workers' compensation claims. Aetna will exercise its recovery rights against the participant.

The recovery rights will be applied even though:

- The workers' compensation benefits are in dispute or are paid by means of settlement or compromise;
- No final determination is made that bodily injury or sickness was sustained in the course of, or resulted from, the participant's employment;
- The amount of workers' compensation benefits due to medical or healthcare is not agreed upon or defined by the participant or the workers' compensation carrier; or
- The medical or healthcare benefits are specifically excluded from the workers' compensation settlement or compromise.

By accepting benefits under this plan, the participant or the participant's representatives agree to notify Aetna of any workers' compensation claim made, and to reimburse Aetna as described above.

General Provisions

Identification Card
The identification card issued by Aetna to participants pursuant to this plan is for identification purposes only. Possession of an Aetna identification card confers no right to services or benefits, and misuse of such identification card may be grounds for termination of participant's coverage pursuant to the Termination of Coverage section of this Certificate. If the participant who misuses the card is the participant, coverage may be terminated for the participant as well as any of the covered dependents. To be eligible for services or benefits, the holder of the card must be a participant on whose behalf all applicable Premium charges have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this plan shall be charged for such services or benefits at billed charges.

If any participant permits the use of the participant's HMO identification card by any other person, such card may be retained by Aetna, and all rights of such participant and their covered dependents, if any, pursuant to this Certificate shall be terminated immediately, subject to the Administrative section.

Reports and Records
Aetna is entitled to receive from any provider of services to participants, information reasonably necessary to administer this Certificate subject to all applicable confidentiality requirements as defined in the General Provisions section. By accepting coverage, the participant, for himself or herself, and for all covered dependents covered hereunder, authorizes each and every provider who renders services to a participant hereunder to:

- Disclose all facts pertaining to the care, treatment and physical condition of the participant to Aetna, or a medical, dental, or mental health professional that Aetna may engage to assist it in reviewing a treatment or claim;
- Render reports pertaining to the care, treatment and physical condition of the participant to Aetna, or a medical, dental, or mental health professional that Aetna may engage to assist it in reviewing a treatment or claim; and
- Permit copying of the participant's records by Aetna.

Refusal of Treatment
A participant may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a participating provider. If the participating provider (after a second participating provider's opinion, if requested by participant) believes that no professionally acceptable alternative exists, and if after being so advised, participant still refuses to follow the recommended treatment or procedure, neither the participating provider, nor Aetna, will have further responsibility to provide any of the benefits available for treatment of such condition or its consequences or related conditions. Aetna will provide written notice to participant of a decision not to provide further benefits for a particular condition. This decision is subject to the Grievance Procedure set forth in the Grievance Procedure section. Coverage for treatment of the condition involved will be resumed in the event participant agrees to follow the recommended treatment or procedure.

Assignment of Benefits
All rights of the participant to receive benefits hereunder are personal to the participant and may not be assigned.

Legal Action
No action at law or in equity may be maintained against Aetna for any expense or bill unless and until the appeal process has been exhausted, and in no even prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in this Group Agreement. No action shall be brought after the expiration of (3) three years after the time written submission of claim is required to be furnished.

Independent Contractor Relationship

- No participating provider or other provider, institution, facility or agency is an agent or employee of Aetna. Neither Aetna nor any participant of HMO is an agent or employee of any participating provider or other provider, institution, facility or agency.
- Neither HCA nor a participant is the agent or representative of Aetna, its agents or employees, or an agent or representative of any participating provider or other person or organization with which Aetna has made or hereafter shall make arrangements for services.
- Participating physicians maintain the physician-patient relationship with participants and are solely responsible to participant for all medical services which are rendered by participating physicians.
- Aetna cannot guarantee the continued participation of any provider or facility with Aetna. In the event a PCP terminates its contract or is terminated by Aetna, Aetna shall provide notification to participants in the following manner:
    - Within thirty days of the termination of a PCP contract to each affected participant, if the participant or any dependent of the participant is currently enrolled in the PCP's office; and
    - Services rendered by a PCP or hospital to an enrollee between the date of termination of the provider Agreement and five business days after notification of the contract termination is mailed to the participant at the participant's last known address shall continue to be covered benefits.
- Restriction on Choice of providers: Unless otherwise approved by Aetna, participants must utilize participating providers and facilities that have contracted with Aetna to provide services.

Inability to Provide Service
In the event that due to circumstances not within the reasonable control of Aetna, including but not limited to: major disaster; epidemic; complete or partial destruction of facilities; riot; civil insurrection; disability of a significant part of the participating provider Network; the rendition of medical or hospital benefits or other services provided under this plan is delayed or rendered impractical; Aetna shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid Premiums held by Aetna on the date such event occurs. Aetna is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

Confidentiality
Information contained in the medical records of participants and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential in accordance with applicable law. Information may not be disclosed without the consent of the participant except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary by Aetna in connection with the administration of this plan, or in the compiling of aggregate statistical data.

Limitation on Services
Except in cases of a medical emergency services are available only from participating providers. Aetna shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a participant from any physician, hospital, skilled nursing facility, home healthcare agency, or other person, entity, institution or organization unless prior arrangements are made by Aetna.

Incontestability
In the absence of fraud, all statements made by a participant shall be considered representations and not warranties, and no statement shall be the basis for voiding coverage or denying a claim after the Group Agreement has been in force for 2 years from its effective date, unless the statement was material to the risk and was contained in a written application.

COBRA

Highlights

When you and/or your covered dependents would otherwise lose health coverage, a federal law known as “COBRA” (which stands for the Consolidated Omnibus Budget Reconciliation Act of 1985) may allow you to pay for continuation of that coverage. COBRA applies to medical, vision, dental and employee assistance coverage, and — in some circumstances — to coverage under the Health Care Flexible Spending Account (the “Health Care FSA”). This section summarizes your options for COBRA continuation of health coverage.

COBRA applies if a “qualifying event” occurs that would otherwise cause you or a covered dependent to lose coverage. COBRA calls each person who would lose coverage a “qualified beneficiary.” A child born to you or placed for adoption with you during your COBRA coverage period is also a qualified beneficiary and is entitled to the same COBRA rights as your other dependents. Each qualified beneficiary has an independent right to elect COBRA coverage. For medical, vision, dental and employee assistance benefits, COBRA coverage can last up to 18 or 36 months, depending on the qualifying event. The 18 months can be extended to 29 months if a disability is involved. For the Health Care FSA, COBRA coverage can last until the end of the plan year in which the qualifying event occurred.

COBRA coverage can be expensive. COBRA premiums can be as much as 102% of the actual cost of providing coverage (150% for disability extensions). Remember that your facility subsidizes part of the cost of non-COBRA medical and dental coverage for active participants and their families. COBRA does not include this employer subsidy, so your COBRA premiums may be quite a bit higher than what you paid as an active participant.

The Medical Plan (including vision), the Dental Plan, the Employee Assistance Program and the Health Flexible Spending Account Plan are group healthcare plans, and you may be enrolled in one or more of these plans. COBRA continuation applies only to group healthcare plans and not to any other benefits offered under LifeTimes Benefit Choices Program, such as life insurance, disability, accidental death or dismemberment benefits or CorePlus Voluntary programs. The plans provide no greater COBRA continuation rights than what COBRA requires — nothing in this Summary Plan Description (SPD) is intended to expand your rights beyond COBRA’s requirements. Only qualified beneficiaries have independent COBRA continuation rights. A domestic partner or children of a domestic partner are not qualified beneficiaries.

Qualifying Events

A “qualifying event” is any of the following events that cause you or another qualified beneficiary to lose coverage under the healthcare plans. Qualifying events for which you or a qualified beneficiary may elect to continue healthcare coverage for you or your qualified beneficiaries under COBRA are:

- Your employment with an HCA-Affiliated Facility ends for a reason other than your gross misconduct
- A reduction in your hours worked that causes a loss of coverage.

Qualifying events for which your covered spouse and/or covered dependents may elect to continue their healthcare coverage under COBRA are:

- You become divorced or legally separated
- You become entitled to Medicare
- Your child is no longer eligible for dependent coverage
- You die

Remember, for COBRA to apply, the event must cause a loss of coverage.

Newborn or Adopted Children

If, during the period of COBRA coverage, you or your eligible spouse gives birth to a child — or if a child is placed with you for adoption — you may elect COBRA continuation coverage for that child. Coverage for the newborn or adopted child will continue for the same period of time that coverage for any other dependent children is or could have been provided.

Special Enrollment Rules for Qualified Beneficiaries

As a qualified beneficiary, you will have the same right to enroll family members under Special Enrollment Rights as if you were a participant within the meaning of those rules.

Losing Coverage

A “loss of coverage” means that, because of the qualifying event, you, your covered spouse and/or your covered dependents cease to be covered on the same terms and conditions as those in effect immediately before the qualifying event. This includes the loss of eligibility for coverage as well as an increase in the cost of coverage caused by the qualifying event. A loss of COBRA coverage itself does not count, however.

Qualified Beneficiaries

A “qualified beneficiary” is each person who, on the day before a qualifying event, is covered under a health plan (other than COBRA continuation coverage) and would lose that coverage because of the qualifying event. For example, in the case of a terminated employee with family coverage, this would be the employee and each covered participant of his or her family. Qualified beneficiaries also include children who are born to you or placed for adoption with you during your COBRA continuation coverage.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. This means that qualified beneficiaries may elect COBRA coverage for themselves, regardless of whether other family members who are also qualified beneficiaries elect or decline coverage.

As a qualified beneficiary, you may change health plans or add/drop eligible dependents at annual enrollment. However, dependents who are not themselves qualified beneficiaries do not become qualified beneficiaries if they are added or dropped at annual enrollment. Special Enrollment Rights may allow a qualified beneficiary to add coverage for new dependents or dependents who lose other coverage, although such added persons do not themselves become qualified beneficiaries (except in the case of your newborn or adopted child or a child placed for adoption with you).

Divorce or Legal Separation

If the participant reduced or eliminated spousal group health coverage in anticipation of a divorce or legal separation, and the divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for the spouse even though the spouse’s coverage was reduced or eliminated, such as at annual enrollment, before the divorce or separation.

Notification of Qualifying Event

The plans will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the participant, or the participant’s becoming entitled to Medicare benefits (under Part A, Part B or both), your affiliated facility must notify the Plan Administrator of the qualifying event.

For other qualifying events (divorce or legal separation of the participant and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify LifeTimes Connection acting for the Plan Administrator within 60 days

after the later of (a) the date of the qualifying event; or (b) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of the qualifying event. You must provide notice within 60 days to LifeTimes at 1-800-566-4114. If you do not timely notify LifeTimes Connection, **YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

Your Choices

COBRA applies only to the Medical (including vision) Plan, Dental Plan, Employee Assistance Program, and in some cases to the Health Care FSA. The right to elect COBRA continuation applies only if the person had the corresponding coverage when the qualifying event occurred. For example, if you had medical and dental coverage but no Health Care FSA, then you would be offered COBRA coverage of medical and dental, but not COBRA coverage of the Health Care FSA. Each qualified beneficiary has an independent right to elect COBRA continuation for healthcare coverages he or she would lose. For example, if you had family healthcare and participated in a Health Care FSA, then you and each covered family member could elect COBRA continuation of medical, dental, vision and/or the Health Care FSA. A parent may elect continuation with respect to any dependent child who is a qualified beneficiary.

However, you cannot decline COBRA coverage for your spouse. Your spouse must decline coverage.

COBRA coverage is the same group healthcare coverage that is offered to similarly situated non-COBRA active participants and dependents. Ordinarily, this would be the same coverage the qualified beneficiary had on the day before the qualifying event occurred.

A Few Words About the Health Care Flexible Spending Account

COBRA applies to the Health Care FSA only for the plan year in which the qualifying event occurred, and then only if the maximum benefit available for the rest of the year under the Health Care FSA is greater than the COBRA premiums for the Health Care FSA for the remainder of that year. You will receive a COBRA election form if you are eligible to continue participation in the Health Care FSA. Note that COBRA contributions for the Health Care FSA are on an after-tax basis, unlike regular premium payments for the Health Care FSA, which are deducted from your paycheck before taxes.

The Benefits

The 18-, 29- and 36-month COBRA continuation periods described here are the maximum times COBRA coverage may last. COBRA coverage ends at midnight on the date any one of the following events occurs:

- The applicable COBRA continuation period ends. This may be 18, 29 or 36 months for the Medical (including vision) Plan, Dental Plan and Employee Assistance Program. For the Health Care FSA, it is the end of the plan year in which the qualifying event occurred
- Premium payments are not made within a 30-day grace period (or 45 days for initial payment). Termination is retroactive to the last day for which payment was made
- Any requirement premium is not paid in full on time
- HCA no longer offers any healthcare coverage to affiliated facility employees
- After the date COBRA is elected, the covered person first becomes covered by another group healthcare plan (not sponsored by HCA) but not before any pre-existing conditions exclusions of the other plan for a pre-existing condition of the covered person have been exhausted or satisfied
- After the date COBRA is elected, the covered person first becomes entitled to Medicare. For this purpose, “entitled” means the effective date of enrollment in either Medicare Part A or B, whichever occurs earlier. It does not mean mere eligibility to enroll
- In the case of a disability extension (namely from 18 to 29 months), there has been a final determination under the Social Security Act that the person is no longer disabled. In this case, COBRA ends on the first day of the month that is more than 30 days after the final determination is issued. This termination provision does not apply, however, if a second qualifying event occurred during the first 18 months of COBRA coverage
- For any reason the plans would terminate coverage of a participant not receiving COBRA coverage, such as fraud

When counting the 18-, 29- or 36-month periods, the periods are measured from the date of the qualifying event, which is the date you lost coverage according to When Coverage Ends under the Eligibility section.

Up to 18 Months

COBRA coverage allows qualified beneficiaries to elect to continue their healthcare coverage for up to 18 months if you or they otherwise would lose coverage because of the following qualifying events:

- Your employment with an HCA-Affiliated Facility ends (unless because of your gross misconduct)
- A reduction in your hours worked causes a loss of coverage

In addition, certain events may extend the 18-month COBRA continuation by another 18 months, to a total of up to 36 months from the original qualifying event:

- **Second Qualifying Event:** If your spouse or dependents experience a second qualifying event within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).

  This extension may be available to the spouse and any dependent children receiving COBRA coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both) or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

  This extension due to a second qualifying event is available only if you notify Planned Benefit Systems (PBS) at 1-877-20-COBRA (26272) within 60 days after the later of (a) the date of the second qualifying event; and (b) the date on which the qualified beneficiary would lose coverage under the terms of the plan. If you do not call PBS during the 60-day notice period, **THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

- **Medicare Entitlement:** If you became entitled to Medicare while employed (even if it was not a qualifying event for your covered dependents because their coverage was not lost or reduced) and then a second qualifying event (for example, your termination of employment or reduction in hours of work) happens within 18 months, your spouse and/or dependents may elect COBRA continuation for up to 36 months from the date you became entitled to Medicare.

  For example, if a covered participant becomes entitled to Medicare eight months before the date on which termination of employment occurs, COBRA continuation for the spouse and children can last up to 36 months after the date of Medicare entitlement which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the end of employment or reduction of the participant's hours of employment, COBRA continuation coverage generally can last for only up to a total of 18 months.

Up to 29 Months
If you or anyone in your family covered under the plans is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum total of 29 months. The disability would have to have started at least at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You must mail or fax a copy of the SSA determination to Planned Benefit Systems (PBS) within 60 days of the SSA determination but before the end of the 18 months of COBRA coverage. If proof is not timely provided within the first 18 months of COBRA coverage, or if these procedures are not followed, or if the notice is not provided in writing to PBS within 60 days of receiving the SSA determination and within 18 month after the covered participant's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE. The disability extension is available only if you notify PBS of the SSA's determination of disability (and provide a copy of the SSA determination) within 60 days after the latest of:

1. The date of the SSA's disability determination;
2. The date of the covered participant's termination of employment or reduction of hours; and
3. The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of the covered participant's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered participant's termination of employment or reduction of hours in order to be entitled to a disability extension. Also, if SSA determines that the qualified beneficiary is no longer disabled, you are required to notify the Plan Administrator within 30 days after this determination.

Up to 36 Months
COBRA allows qualified beneficiaries to elect to continue their healthcare coverage (except the Health Care FSA) for up to 36 months if they otherwise would lose coverage because one of the following qualifying events:

- You become divorced or legally separated
- You become entitled to Medicare. For this purpose, "entitled" means the effective date of enrollment in either Medicare Part A or B, whichever occurs earlier. It does not mean mere eligibility to enroll
- Your child is no longer eligible for dependent coverage
- You die

Steps to Follow

Electing COBRA Coverage
To elect COBRA coverage, you must complete the Election Form that is part of the COBRA election notice and mail or fax it to Planned Benefit Systems (PBS). (An election notice will be provided to qualified beneficiaries at the time of a qualifying event.) You may also obtain a copy of the Election Form from Planned Benefit Systems (PBS) at 1-877-20-COBRA (26272).

If mailed, your election must be postmarked, or if sent via facsimile, your election must be received no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event or within 60 days of the date coverage is lost because of a qualifying event. **IF YOU DO NOT TIMELY ELECT COBRA COVERAGE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.** Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the COBRA election notice **WILL LOSE HIS/HER RIGHT TO ELECT COBRA COVERAGE.**

Special Consideration Concerning COBRA Election
In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having preexisting conditions exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA may help you not to have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you have Special Enrollment Rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under these plans ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Divorce or Separation or Child's Becoming Ineligible
If you divorce or become legally separated, or your child reaches the maximum age for coverage (19 or 26) or marries, and you have healthcare coverage for any of these persons, then you must notify LifeTimes Connection of these events by calling 1-800-566-4114. You must call within 60 days from the date of the event or, if later, from the date your spouse or dependent would lose coverage because of the qualifying event. The representative will notify the COBRA Administrator — PBS — of the qualifying event. PBS will then send any qualified beneficiaries a COBRA notice at their last known address describing their continuation options and premiums, along with a form for electing continuation coverage. If you or your dependent is already continuing coverage through COBRA, contact PBS directly.

All Other Initial Qualifying Events
For all other initial qualifying events, the COBRA Administrator will notify any qualified beneficiaries — at their last known address — of the right to continue healthcare coverage under COBRA. The notice will describe the continuation options and premiums, and it will contain a form for electing continuation coverage.

Returning the Election Form and Payment
To elect COBRA coverage, return the election form to the COBRA Administrator within 60 days and pay the initial premium within 45 days of the election. Any qualified beneficiaries who wish to continue healthcare coverage must return the election form to the COBRA Administrator within 60 days from the date notice is provided or coverage is lost because of the qualifying event, whichever is later. Each qualified beneficiary has an independent right to elect COBRA coverage. However, if a participant or spouse elects coverage but does not specify that it is only for himself or herself, then that election is deemed to include an election of coverage on behalf of all other qualified beneficiaries with respect to that qualifying event. If no response is made by the deadline, then the right to continue coverage is lost.

Disability Extension
To extend coverage to 29 months because of a qualified beneficiary's disability, a qualified beneficiary must notify the COBRA Administrator of the disability. If the qualified beneficiary is approved by the Social Security Administration for disability income within 18 months of the COBRA qualifying event and the disability income is retroactive so that the disability existed on the date of the qualifying event or within the first 60 days of COBRA coverage, a qualified beneficiary must notify the COBRA Administrator within 60 days of the determination and within the 18-month period in order to qualify for the disability extension by forwarding a copy of the letter from the Social Security Administration.

Contacting the COBRA Administrator
If you have questions about COBRA eligibility or coverage, call the COBRA Administrator and speak to a COBRA Representative, or write to:

Planned Benefit Systems (PBS)
ATTN: COBRA Administrator
P.O. Box 4594
Greenwood Village, CO 80155-4594
1-877-20-COBRA or 1-877-202-6272

What Else You Should Know

Cost
As noted earlier, COBRA coverage can be expensive. COBRA premiums can be as much as 102% of the actual cost of providing coverage (150% for certain disability extensions). This may be quite a bit higher than what you pay as an active participant, because your facility subsidizes part of the cost of non-COBRA medical and dental coverage and all of the employee assistance coverage for active participants and their families, but COBRA payments do not include your facility's subsidy.

When a qualified beneficiary becomes entitled to COBRA continuation coverage, he or she will receive a notice explaining the continuation options and how to elect them. That notice will state the premium costs associated with those options.

You must pay premiums at the times specified. Your initial payment (including all unpaid premiums retroactive to the date coverage otherwise would have ended) is due within 45 days after the date you elect COBRA. All other premium payments have a 30-day grace period.

Special rules apply to the cost of disability extensions. For disability extensions (months 19 – 29), the COBRA premiums may be up to 150% of the actual cost of providing coverage. (For months 1 – 18, the premiums remain at 102%, even if the person is disabled.) The premiums for the 19th through 29th months of coverage under the disability extension are 150% of the full cost of coverage for all family members participating in the same coverage option as the disabled individual, but are 102% for any family members participating in a different coverage option than the disabled individual. However, if a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the individual is disabled.

If a second qualifying event occurs during the disability extension period (that is, during the 19th through 29th months), then the rate for the 19th through 36th months is 150% for all family members participating in the same coverage option as the disabled individual, but still 102% for any family members in a different coverage option from the disabled individual.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes by Planned Benefit Systems (PBS). If you have any questions concerning the amount of COBRA premiums, call Planned Benefit Systems (PBS) at 1-877-20-COBRA (26272).

Payment for COBRA Coverage
All COBRA premiums must be paid by check or money order. Your first payment and all monthly payments for COBRA coverage must be mailed to:

Planned Benefit Systems (PBS)
P.O. Box 4594
Greenwood Village, CO 80155-4594

Your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

If you timely elect COBRA, you do not have to send any payment initially. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election and the amount must include all payments through the end of the month in which you make your first payment. For example, Sue's employment terminates September 15 and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October, November and December and is due on or before December 30, the 45th day after the date of her COBRA election.

You are responsible for making sure that the amount of your first payment is correct. You may contact Planned Benefit Systems (PBS) at 1-877-20-COBRA (26272) to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Each of these monthly payments for COBRA coverage is due on the first day of the month for that month's coverage. If you make a monthly payment or before the first day of the month to which it applies, your COBRA coverage will continue for that month without any break. Planned Benefit Systems (PBS) will not send periodic notices of payments due for these coverage period (that is, **you will not be sent a bill for your COBRA coverage — it is your responsibility to pay your COBRA premiums on time**).

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. For example, the April payment is due April 1 and the grace period ends April 30. If you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

Your Right to a Certificate of Creditable Coverage
When your active coverage ends, LifeTimes Connection will provide a written certification — called a "certificate of creditable coverage" — of how long your coverage was in effect. You may also request this certification from the COBRA Administrator (PBS) at any time within the 24-month period after your coverage ends. The purpose of this coverage certification is to help satisfy another plan's pre-existing condition limitation. If you become covered by a plan that has a pre-existing condition exclusion, you may use the certificate to show your new plan how long you had coverage under your old plan. If you do not have a certificate, you can prove your prior coverage by producing documentation or other evidence. The new plan must notify you of any length of time that a pre-existing condition exclusion may apply to you after counting your previous coverage.

Other Group Health Coverage
If any qualified beneficiary becomes covered under another group healthcare plan after COBRA continuation coverage has been elected, you or that beneficiary must notify the COBRA Administrator (PBS) immediately. COBRA coverage for that qualified beneficiary may be terminated if the other coverage does not contain a pre-existing condition limitation that applies to the qualified beneficiary.

COBRA and the Family and Medical Leave Act (FMLA)
The taking of an FMLA leave is not a qualifying event. However, if you fail to return to employment with an HCA-Affiliated Facility at the end of your FMLA leave, then you and any of your dependents who had healthcare coverage when the leave began — and who otherwise would lose that coverage because of your failure to return — would experience a qualifying event on the last day of the FMLA leave or, if later, the day coverage is lost. COBRA notices and election forms would be sent accordingly to any qualified beneficiaries at that time. You do not have to continue healthcare coverage during your FMLA leave to be eligible for COBRA, and your right to COBRA continuation coverage cannot be conditioned upon repayment of any premiums your facility may have paid on your behalf during FMLA leave.

COBRA and Bankruptcy
Special COBRA rules apply to retirees if HCA goes into bankruptcy. In the unlikely event such a bankruptcy occurs, affected persons will receive notice of their COBRA rights.

Qualified Medical Child Support Orders
A child of the covered participant who is receiving benefits pursuant to a qualified medical child support order received by LifeTimes Connection during the covered participant's period of employment is entitled to the same rights to elect COBRA as an eligible dependent child of the covered participant.

Trade Act of 2002
The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individual). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

COBRA and USERRA
When you are called to active duty, you may be covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA) and COBRA. Any benefit continuation for USERRA and COBRA will cause the time periods to run concurrently.

Administrative Information

For administrative information for benefit plans other than this self-insured HMO plan, please refer to the "HCA Benefit Plans Summary Plan Descriptions (as of December 2007)" and associated Summaries of Material Modifications. Log on to HCArewards.com for the online version of these other materials or call LifeTimes Connection at (800) 566-4114 if you need a hard copy.

Highlights

It is important that you understand basic administrative information about your benefits. You may need this information if:

- You change your address
- You want to know how distributions are taxed and how they can rollover tax-free
- A claim for health and group or retirement benefits has been denied and you want to know how to appeal (see below)
- You want to know your basic rights with respect to benefits
- You want to know HCA's rights with respect to benefits
- You want to know when benefits may be changed or terminated
- You are eligible for continuation of group health coverage under COBRA
- You want to know how distributions are taxed and how they can roll over tax-free
- You get divorced
- You need basic plan or program administrative information

Keep Your Address Current

If your most recent address is not on file with your Human Resources Department or LifeTimes Connection, and your facility cannot locate you, benefits may be delayed. Be sure to keep your address current by contacting your local Human Resources Department (if you are currently an employee) or LifeTimes Connection (if you have terminated your employment).

Claims and Appeals

Making a Claim

Each plan or benefits option has its own procedures and time limits for making claims. Refer to the appropriate section for more information about the particular benefits at issue and combine that information with the discussion that follows. You may designate an authorized representative to act on your behalf in pursuing a benefit claim or appealing a claim denial.

Claims will be either an eligibility claim or a benefit claim.

Definition of an Eligibility Claim

An "eligibility claim" is a claim to participate in a plan option or to change an election to participate during the year. For example, it may be a claim to start, add or stop participation in the plan.

Definition of a Benefit Claim

A "benefit claim" includes any claim that is not a claim for eligibility, such as a request for medical plan benefits. A benefit claim includes:

- **Urgent care claims** — Claims for medical care or treatment for which using the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or — in the opinion of a physician with knowledge of the claimant's medical condition — would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim
- **Concurrent care claims** — Claims related to an approved, ongoing course of treatment over a period of time or number of treatments
- **Pre-service claims** — Claims for benefits for which the plan requires prior approval of the benefit before you receive medical care
- **Post-service claims** — Claims for benefits that are not pre-service or urgent care claims

When you file a claim, the Claims Administrator reviews the claim and makes the initial decision to either approve or deny the claim.

If you fail to follow the plan's procedures for filing a pre-service or urgent claim, you'll be notified of this failure and the plan's procedures for filing a claim for benefits. This failure involves a communication — made by you or your authorized

representative to a person or unit customarily responsible for handling benefit matters — that does name a specific claimant, specific medical condition or symptom and a specific treatment, service or product for which approval is requested but for some other reason does not follow the plan's claims procedures. In the case of a failure in a pre-service claim, you'll be notified no later than five days (24 hours in case of a failure to file a claim involving urgent care) after the failure. You may be notified orally, unless you request written notification.

Understanding a Claim Denial
A claim denial may take more than one form. It may be a denial of the claim itself, or it may be a reduction or termination of the benefits you are seeking (or have been receiving), or it may be a decision not to provide or make payment for a particular benefit.

If any of these occurs, you will receive written notice within the required time limits below. The notice will:

- Set forth the specific reason(s) for the denial
- Refer to the specific plan provisions on which the decision is based
- Describe what additional material or information from you, if any, is necessary, and explain why that material or information is necessary
- Describe the plan's review (appeal) procedures and the time limits applicable to those procedures, and state your right to sue under section 502(a) of ERISA, 29 U.S.C. § 1132(a), if your appeal is denied

If an internal rule, guideline, protocol or similar criterion is relied upon to make the adverse determination, the notice will either contain that rule, etc., or state that such a rule, etc., was relied upon and that you may receive a free copy of it upon request.

For all urgent claims, the notification will also contain a description of the expedited review process applicable to such claims.

If the benefit determination is based on medical necessity, experimental treatment or similar exclusion or limit, the notification must also contain either:

- An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan, as applicable, to the claimant's medical circumstances; or
- A statement that such explanation will be provided free of charge upon request

Statute of Limitations

Type of Claim:	Time Limits for Notice of Claim Decision:	Extension of Time Limits:
Healthcare claims: Urgent care	As soon as possible, taking into account the medical demands, but no later than 72 hours after receipt of the claim by the plan, HMO or carrier	If additional information is needed, you'll be notified with 24 hours after receipt of the claim as to what additional information is needed, and you'll have 48 hours to provide this information. The plan, HMO or carrier must respond no later than 48 hours after the earlier of the receipt of the information or the end of the period you're given to provide the information
Healthcare claims: Concurrent care decisions	• Non-urgent claims for ongoing care (reduction or elimination of a course of treatment before the end of the course of treatment or number of treatments) — Sufficiently in advance of the reduction or termination of a course of treatment to allow the claimant time to appeal and obtain a review before the benefit is reduced or eliminated • Urgent claims for ongoing care (extension of the course of treatment or number of treatments) — As soon as possible, taking into account the medical demands, but no later than 24 hours after receipt of the claim by the plan, HMO or carrier, If received 24 hours prior to the end of the course of treatment	• If necessary, the period may be extended one time for 15 days. If an extension is necessary because additional information is needed, the extension notice will describe the information needed, and you'll have at least 45 days to provide the information • If the concurrent care is considered urgent, you'll fall under the urgent care rules described above
Healthcare claims: Pre-service	Within a reasonable period of time appropriate to the medical circumstances but no later than 15 days after receipt of the claim by the plan, HMO or carrier	If necessary, the period may be extended one time for 15 days. If an extension is necessary because additional information is needed, the extension notice will describe the information needed, and you'll have at least 45 days to provide the information
Healthcare claims Post-service	Within a reasonable time period, but no later than 30 days after receipt of the claim by the plan, HMO or carrier	If necessary, the period may be extended one time for 15 days. If an extension is necessary because additional information is needed, the extension notice will describe the information needed, and you'll nave at least 45 days to proved the information

A few words about counting time under these deadlines: The time period begins when a claim is filed in accordance with the reasonable procedures of the plan, without regard to whether the claim includes all the necessary information. If time is extended because you failed to provide necessary information, then the extension period will be “tolled” (in other words, days will not count against the extension limits) from the date notice of the extension is sent until the date you respond to the request for additional information.

Request for Review if Your Claim Is Denied
You have the right to request a review of a claim’s denial:

- You, or your authorized representative, shall be entitled to request a review of this denial upon written application
- You have the right to examine the relevant documents that establish and control the plan. These documents may be seen in the office of the Plan Administrator upon request
- You, or your representative may submit additional documents or comments in writing if you believe such items would reverse the denial of your claim

Types of Review or Appeal
Certain reviews or appeals have a one-step appeal procedure and other appeals have a two-step appeal procedure. This chart indicates the appeal levels available in most situations. However, if you are covered by an HMO or Dental HMO, you must refer to your booklet for their specific procedures.

Type of Claim:	Appeal Procedure:
Healthcare: Urgent Care	One-step with Claims Administrator
Healthcare: Concurrent Care	One-step with Claims Administrator
Healthcare: Pre-Service	One-step with Claims Administrator
Healthcare: Post-Service	One-step with Claims Administrator and One-step with Benefit Appeals Committee
Behavioral Health – Self-Insured HMO	Same as Healthcare listed above
Prescription Drug (retail or mail-order)	Same as Healthcare listed above

Where to Send Appeals
For Self-Insured HMO Appeals: If you wish to appeal an urgent care, concurrent care or pre-service claim, the Claims Administrator identified on your medical ID card is the designated party and determines all claim issues including the one-step appeal procedure.

If you wish to appeal a post-service claim, the Claims Administrator identified on your medical ID card is the designated party for the initial claim determination and first level of appeal. The Benefit Appeals Committee for the Medical Plan is the fiduciary for the second level of appeal.

In General
At each level of appeal you will receive a full and fair review of the claim and its denial. The review will not be performed by the same individual who made the initial determination on the claim. Also, you must complete the entire appeal process (whether one-step or two-step) as a precondition to filing a lawsuit or suing for benefits under section 502(a) of ERISA.

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim. The review of the appeal will take into account all of the information you submit related to your claim, without regard to whether it was submitted or considered in the initial claim decision.

At your request, you will have reasonable access to and may have copies (without charge) of all documents, records and other information relevant to your claim. For this purpose, “relevant” means the item:

- Was relied upon in making the benefit determination;
- Was submitted, considered or generated in the course of making the benefit determination (even if not relied upon);
- Demonstrates compliance with the administrative process and safeguards for ensuring that claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently to similarly-situated individuals; or
- Is a statement of the policy or guidance for your diagnosis (even if not relied upon)

Required Information to Submit a Self-Insured HMO Appeal
To be considered an appeal you must submit (a) a copy of the Explanation of Benefits (EOB) for the disputed claim, (b) an explanation which describes the basis of your appeal, (c) your name and home address and (d) any additional information or documentation supporting your appeal. If you submit an incomplete appeal, you will be notified in writing of the missing items and your request is not considered an appeal until it is complete.

For appeals which are submitted to the Benefit Appeals Committee, you must submit (a) a copy of the EOB for the disputed claim, (b) a copy of the first appeal letter, (c) denial letter from the Claims Administrator, (d) an explanation which describes the basis of your second appeal, (e) your name and home address and (f) any additional information or documentation supporting your appeal. If you submit an incomplete appeal, you will be notified in writing of the missing items and your request is not considered an appeal until it is complete.

Notice of Decision on Appeal

Type of Claim:	Notice of Decision on Appeal:
Healthcare: Urgent Care	As soon as possible, taking into account the medical demands, but no later than 72 hours after receipt of the appeal by the Claims Administrator.
Healthcare: Concurrent Care	If an urgent claim for ongoing care, within 72 hours. If a non-urgent claim for ongoing care, timing of the notice of decision on appeal will either be handled under pre-service or post-service claim time frames addressed below (depending on the type of claim).
Healthcare: Pre-Service	A reasonable time period appropriate to the medical circumstances but no later than 30 days after receipt of the request for appeal by the Claims Administrator.
Healthcare: Post-Service	A reasonable time period for first appeal but no later than 30 days after receipt of the appeal by the Claims Administrator. A reasonable time period for the second appeal but no later than 30 days after receipt of the second appeal by the Benefit Appeals Committee.
Behavioral Health	See Healthcare above.
Prescription Drug (retail or mail-order)	See Healthcare above.

Time Periods to Appeal
The time period for a self-insured HMO appeal is 9 months from the original denial.

In addition, your claim will be reviewed anew on appeal. No deference will be given to the original denial. The review will be conducted by an appropriate named fiduciary of the plan who is not (and is not subordinate to) the person who made the original claim denial. If the decision is based in whole or part on medical judgment, then the review will include consultation with a healthcare professional who has appropriate training and experience in the field of medicine involved, and who was not consulted with (and is not subordinate to someone who was consulted with) about the original denial. Any medical or vocational experts consulted in connection with your claim will be identified, without regard to whether their advice was relied upon in making the determination.

For all appeals, you will receive written notice of the decision on appeal within the required time limits. If your appeal is denied (in whole or part), the notice will:

- Set forth the specific reason(s) for the denial
- Refer to the specific plan provisions on which the decision is based
- State that you are entitled to receive, upon request, reasonable access to and free copies of all documents, records and other information relevant to your claim
- Describe procedures for further appeal, if any, and the time limits applicable to those procedures, and state your right to sue under section 502(a) of ERISA, 29 U.S.C. § 1132(a)
- State that you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state's insurance regulatory agency

If an internal rule, guideline, protocol or similar criterion is relied upon to decide your appeal, the notice will either contain that rule, etc., or state that such a rule, etc., was relied upon and that you may receive a free copy of it upon request.

For medical, dental and disability claims only, if the benefit determination is based on medical necessity, experimental treatment or similar exclusion or limit, the notification must also contain either:

- An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan, as applicable, to the claimant's medical circumstances; or
- A statement that such explanation will be provided free of charge upon request

For all urgent claims, the notification will also contain a description of the expedited review process applicable to such claims.

Although you ordinarily should receive notice of the determination on appeal within the required time limits, special circumstances sometimes may require an extension of time for processing an appeal of a claim that does not involve medical, dental or vision benefits. If it is determined that an extension is required, written notice of the extension will be provided to you prior to the end of the notice period. This extension notice will indicate the special circumstances requiring the extension and the date by which a decision is expected.

The specific time periods begin when an appeal is filed in accordance with the reasonable procedures of the plan, without regard to whether the appeal includes all the necessary information. Except for medical benefit claims if time is extended because you failed to provide necessary information, then the extension period will be "tolled" (in other words, days will not count against the extension limits) from the date notice of the extension is sent until the date you respond to the request for additional information.

Statute of Limitations

For self-insured benefits, no legal action may be taken if such action is filed more than one year after a claim is denied.

Your Rights

As a participant in HCA's benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receiving Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Obtain a statement telling you whether you have a right to receive a retirement benefit at normal retirement age (age 65) and if so, what are your retirement benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a retirement benefit, the statement will tell you how many more years you have to work to get a right to a retirement benefit. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

Continuing Group Health Plan Coverage

- Continue healthcare coverage for yourself, spouse or dependents under COBRA if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.
- You may be eligible for a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA. If your claim for a benefit is denied or ignored — in whole or in part — you have a right to know why this was done, to obtain copies of documents relating to the decision without charges, and to appeal any denial, all within certain time schedules.

Enforcing Your Rights

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of the plan documents or the latest of any report and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials — unless the materials were not sent because of reasons beyond the control of the Administrator.
- If you have a claim for benefits, which is denied or ignored — in whole or in part — you may file suit in a state or federal court, but only after you have exhausted the plan's claims and appeals procedures.
- If you disagree with the plan's decision or lack of response to your request concerning the qualified status of a qualified medical child support order (QMSCO), you may file suit in federal court.

- If it should happen that plan fiduciaries misuse the plan's money, or if you're discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

If you file suit against the plan, the court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — for example, if it finds your claim is frivolous.

Getting Answers to Your Questions
If you have any questions about your plan, you should contact the Plan Administrator (for health and welfare plans) or call LifeTimes Connection at 1-800-566-4114 (for retirement and savings plans). If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA at 1-866-444-3272, by logging on to the Internet at www.dol.gov/ebsa, or by contacting the EBSA field office nearest you.

Special Rights When Having a Baby
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HCA's Rights

HCA provides the benefits described in this Summary Plan Description (SPD) as part of your total compensation package. However, HCA does not guarantee that these benefits will continue, and the offering of such benefits and the enrollment in the various plans and programs does not guarantee your employment. The Company's employment decisions are made without regard to the benefits to which you are or may be entitled due to employment. This SPD does not constitute an expressed or implied contract to guarantee of employment.

If you terminate employment or are discharged, you have no right to benefits unless these rights are specifically provided for in the plans or required by law.

This SPD provides important benefit plan information. If differences exist between this material and the plan documents, the plan documents always govern. The plan documents are on file with the Plan Administrator. HCA has the right to amend or terminate the plans at any time.

Future of the Health and Group Plans
HCA intends to continue operating these plans and programs indefinitely, but future business conditions or other reasons could cause the company to discontinue them. If so, valid claims for healthcare and death benefits pending at the time would be paid to the extent allowable under the terms of the plan or program. HCA reserves the right to terminate the plans at any time. The plans will end automatically if HCA ceases to exist and no successor company continues the plans.

When Benefits May Change or End
Subject to special statutory rules regarding plan amendments, and to the fullest extent allowed by law, HCA reserves the right to amend or terminate any of the benefits described in this SPD, as well as any of their underlying insurance or HMO policies, contracts or agreements, in whole or in part, both prospectively and retroactively, at any time, with or without notice. However, any retroactive amendment will not affect a claim already incurred, except as necessary to comply with federal law.

Benefit plans are amended or terminated as provided in the plan's documents.

Any underlying insurance or HMO policies, contracts or agreements are amended or terminated according to their terms.

Basic Administrative Information

Plan Year, Plan Sponsor and Plan Administrator
The plan year for the self-insured HMO plans is the same as the calendar year — January 1 through December 31.

HCA Inc. is the Plan Sponsor for the self-insured HMO plans. The address is:

HCA Inc.
One Park Plaza, 1-2W
Nashville, TN 37203

HCA's Employer Identification Number (EIN) is 75-2497104.

The HCA Plan Administration Committee is the Plan Administrator for the self-insured HMO plans. The address and phone number are:

Plan Administration Committee
c/o HCA Inc.
One Park Plaza, 1-2W
Nashville, TN 37203
1-615-344-9551

The Plan Administration Committee uses the help of many persons and organizations, including LifeTimes Connection, in administering the plans. If you have questions about these plans, you can visit HCArewards.com or call LifeTimes Connection at 1-800-566-4114.

If LifeTimes Connection cannot answer your question, you should contact:

HCA Inc.
Plan Administration Committee
c/o Human Resources Department
One Park Plaza, I-2W
Nashville, TN 37203

Plan Administrator Discretion
The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which each plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefits under the terms of a plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under certain plans described in this SPD constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described in the applicable section.

The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities. Such delegation of authority must be in writing, and must identify the delegate and the scope of the delegated responsibilities.

Agent for Service of Legal Process
The name and address of the designated agent for service of legal process are:

General Counsel/Secretary
HCA Inc.
One Park Plaza, I-2E
Nashville, TN 37203

Legal process also can be served on the Plan Administrator or Trustee.

Plan Structure
This SPD describes one of HCA's self-insured HMO plans.

This material is intended to summarize HCA's benefits in non-technical language. The benefits themselves are governed by their respective plan documents, and any underlying insurance or HMO policies, contracts or agreements, and collective

bargaining agreements, if any. In the event of a conflict between this SPD and any of these other documents, the other documents control.

One or more of the plans are maintained pursuant to one or more collective bargaining agreements. Participants or beneficiaries may obtain a copy of the collective bargaining agreement upon written request to the Plan Administrator. The collective bargaining agreements are available for examination by participants or beneficiaries covered by those agreements.

Funding
Self-insured HMO coverage is funded by the payment of insurance premiums from participants and, if applicable, HCA's affiliated facilities to various vendors. The benefits for these coverages are paid according to the terms of those contracts.

There are no insurance contracts. Participant and HCA-Affiliated facility contributions are paid into an HCA established trust — the Voluntary Employees' Beneficiary Association Trust (VEBA) — which is an IRC 501(c)(9) trust. Benefits are paid from the VEBA. The trustee is Bank of America.

Plan Identification Information

Plan Name:	Plan Number:	Plan Type:	Claims Administrator:	Funded By:
Medical Plan: Self-Insured HMO	501	Welfare/Healthcare	Refer to your medical ID card for Claims Administrator information	Insurance contracts, HMOs and a trust. Shared facility and employee contributions Trustee: Bank of America R/1-536-05-03 100 Westminster Street Providence, RI 02903

Key Terms

Actively at Work: The condition where an employee is performing all of the participant's regular duties for HCA (the participant's employer) on a regularly scheduled work day, at the location where such duties are normally performed, and on a full-time basis. An employee will be deemed to be Actively at Work on a non-scheduled work day only if such person is Actively at Work on the last regularly scheduled work day immediately preceding such non-scheduled work day.

Allowable Amount: The Medical Plan pays benefits based on the allowable amount (sometimes referred to as "reasonable and customary charges") for that service. When determining the allowable amount, the Claims Administrator considers factors such as the complexity of the treatment, the degree of skill needed to provide the treatment, the provider's specialty, the range of services and supplies provided by the facility or provider, and the prevailing charge in the same area for that service. You will be responsible for any amounts over the allowable amount.

Allowable Expense: Any necessary and reasonable health expense, part or all of which is covered under any of the plans covering the participant for whom claim is made.

Annual Maximum: Under a benefit plan, the maximum benefit payable for a covered person during the plan year.

Basic Living Expenses: Basic Living Expenses means shelter, utilities and all other costs directly related to the maintenance of the common household of the shared residence of the domestic partners. It also means any other cost, such as medical care, if some or all of the cost is paid as a benefit because a person is another person's domestic partner.

Behavioral Health Provider: A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Bone Mass Measurement: A radiologic or radioisotopic procedure or other scientifically proven technologies performed on a participant for the purpose of identifying bone mass or detecting bone loss.

Brand Name Prescription Drug(s): Prescription drugs and insulin with a proprietary name assigned to it by the manufacturer or distributor and so indicated by MediSpan or any other similar publication designated by Aetna or an affiliate. Brand name prescription drugs do not include those drugs classified as generic prescription drugs as defined below.

"Cafeteria" Plan: A benefit plan under Section 125 of the Internal Revenue Code that allows you to choose among two or more benefits consisting of cash and qualified benefits. Generally, cafeteria plans allow you to pay premiums for benefits on a before-tax basis and elections may only be changed during annual enrollment, except in limited circumstances.

Cash-Out Dollars: Taxable money that you may receive if you waive certain benefits. Cash-Out Dollars are considered taxable income and will be taxed in the same way that your current pay is taxed. You can view the amount of Cash-Out Dollars available to you by logging on to LifeTimes Connection at HCArewards.com.

Claims Administrator: The company responsible for administering and paying claims under a benefit plan.

Coinsurance: The percent of covered expenses that you must pay after the annual deductible, if applicable. For example, if the plan pays 80% of covered expenses, your coinsurance — after you pay your annual deductible — is 20%.

Coordination of Benefits: A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical; dental; or other care or treatment. It may avoid claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first. Refer to the Coordination of Benefits section for a description of the Coordination of Benefits provision.

Copayment (or Copay): The dollar amount that you pay to the network provider each time you receive a covered service — for example, a $15 copay for an office visit. The balance of the cost for care is usually paid at 100%. Copays do not count toward the deductible and there are no copay maximums.

Copayment Maximum: The maximum annual out-of-pocket amount for payment of copayments, if any, to be paid by a participant and any covered dependents, if any.

Cosmetic Surgery: Any non-medically necessary surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem but which does not: restore bodily function; correct a diseased state; physical appearance; or disfigurement caused by an accident; birth defect; or correct or naturally improve a physiological function.
Cosmetic Surgery includes, but is not limited to: ear piercing; rhinoplasty; lipectomy; surgery for sagging or extra skin; any augmentation or reduction procedures (e.g., mammoplasty; liposuction; keloids; rhinoplasty and associated surgery); or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Dependent: Any person in a participant's family who meets all the eligibility requirements of the Eligibility section and the dependent Eligibility section of the Schedule of Benefits, has enrolled in HMO, and is subject to Premium requirements set forth in the Premiums section of the Group Agreement.

Covered Benefits: Those medically necessary services and supplies set forth in this plan, which are covered subject to all of the terms and conditions of the Group Agreement and Certificate.

Creditable Coverage: Coverage of the participant under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored healthcare (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, and any health benefit plan under section 5(e) of the Peace Corps Act. Creditable Coverage does not include coverage only for accident; workers' compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited scope dental benefits, limited-scope vision benefits, or long-term care benefits that are provided in a separate policy.

Custodial Care: Services and supplies that are primarily intended to help a participant meet their personal needs. Care can be custodial care even if it is prescribed by a physician, delivered by trained medical personnel, or even if it involves artificial methods (or equipment) such as feeding tubes, monitors, catheters. Examples of custodial care include, but are not limited to:

- Changing dressings and bandages, periodic turning and positioning in bed, administering oral medication, watching or protecting a participant.
- Care of a stable tracheostomy, including intermittent suctioning.
- Care of a stable colostomy/ileostomy.
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings.
- Care of a stable indwelling bladder catheter, including emptying/changing containers and clamping tubing.
- Respite care, adult (or child) day care, or convalescent care.
- Helping a participant perform an activity of daily living, such as: walking, grooming, bathing, dressing, getting in and out of bed, toileting, eating, or preparing food.
- Any services that an individual without medical or paramedical training can perform or be trained to perform.

Detoxification: The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed physician while keeping the physiological risk to the patient at a minimum.

Drug Formulary: A list of prescription drugs and insulin established by Aetna or an affiliate, which includes both brand name prescription drugs, and generic prescription drugs. This list is subject to periodic review and modification by Aetna or an affiliate. A copy of the drug formulary will be available upon request by the participant or may be accessed on the Aetna Web site located on the Benefit Providers page at HCArewards.com.

Drug Formulary Exclusions List: A list of prescription drugs excluded from the drug formulary, subject to change from time to time at the sole discretion of Aetna.

Durable Medical Equipment: Equipment, as determined by Aetna, which is: a) made to withstand prolonged use; b) made for and mainly used in the treatment of a disease or injury; c) suited for use while not confined as an inpatient in the hospital; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.

Eligible Pay: For purposes of Health & Group plans, your eligible pay generally includes all wages reported on your W-2 form, including your contributions to the plan and any before-tax dollars you use to pay for additional benefits through the LifeTimes Benefit Choices Program. Pay also includes any retention bonuses you receive. If your eligible pay increases during the year because of a raise or promotion, your contributions for the balance of the year are based on the increased amount. There are some exceptions to eligible pay.

Eligible Provider: For purposes of the plan, eligible provider means a licensed, practicing physician. The definition includes:

- Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), (except an intern or resident)
- Doctor of Dental Medicine (D.D.M.)
- Doctor of Dental Surgery (D.D.S.)
- Doctor of Optometry (O.D.)
- Doctor of Surgical Chiropody (D.S.C.)
- Doctor of Chiropractic (D.C.)
- Licensed Podiatrist
- Licensed Midwife
- Physician Assistant
- Surgical First Assistant, including, M.D.s, D.O.s, D.M.D.s, D.D.S.s, C.S.A.s, C.F.A.s, R.N.F.A.s, C.S.T.s and Physician Assistants provided they are licensed in the state which the surgery is performed
- Any other provider who meets this plan's definition of doctor as determined by the plan administrator and is operating within the scope of his or her license

Emergency Service: Professional health services that are provided to treat a medical emergency.

Experimental or Investigational Procedures: Services or supplies that are, as determined by Aetna, experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug; device; procedure; or treatment; or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of a participant's particular condition; or it is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of a participant's particular condition; or
- It is provided or performed in special settings for research purposes.

Generic Prescription Drug(s): Prescription drugs and insulin, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by MediSpan or any other similar publication designated by Aetna or an affiliate.

HCA: The term “HCA” refers to HCA Inc. and its affiliated facilities, unless otherwise stated. HCA Inc. is a holding company, which has no employees.

HMO: Aetna Health Inc., a Tennessee corporation licensed by the Tennessee Department of Commerce and Insurance as a Health Maintenance Organization.

Homebound Participant: A participant who is confined to their place of residence due to an illness or injury which makes leaving the home medically contraindicated or if the act of transport would be a serious risk to their life or health. Examples where a participant would not be considered homebound are:

- A participant who does not often travel from home because of feebleness and/or insecurity brought on by advanced age (or otherwise).
- A wheelchair bound participant who could safely be transported via wheelchair accessible transport.

Home Health Services: Those items and services provided by participating providers as an alternative to hospitalization, and approved and coordinated in advance by Aetna.

Hospice Care: A program of care that is provided by a hospital; skilled nursing facility; hospice; or a duly licensed Hospice care agency; and is approved by Aetna, and is focused on a palliative rather than curative treatment for participants who have a medical condition and a prognosis of less than 6 months to live.

Hospital: An institution rendering inpatient and outpatient services, accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna as meeting reasonable standards. A hospital may be a general; acute care; rehabilitation; or specialty institution.

Infertile or Infertility: The condition of a presumably healthy participant who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual sexual intercourse. This does not include conditions for male participants when the cause is a vasectomy or orchiectomy or for female participants when the cause is a tubal ligation or hysterectomy.

Lifetime Maximum: Under a benefit plan, the maximum amount payable for a covered person during the combined time of coverage.

LifeTimes Connection: LifeTimes Connection is HCA’s benefits information system that allows you to access automated information about your benefits through the Web site or interactive voice response system, or to speak to a Benefits Center Representative.

Maintenance Drug(s): A listing of prescription drugs or medications established by Aetna or an affiliate which is subject to periodic review and modification by Aetna or an affiliate. The list consists of prescription drugs or medications that are taken for extended periods of time, and which do not vary frequently in terms of dosage (such as high blood pressure medication).

Medical Community: A majority of physicians who are Board Certified in the appropriate specialty.

Medical Emergency: The existence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

Medical Services: The professional services of health professionals, medical; surgical; diagnostic; therapeutic; preventive care; and birthing facility services.

Medically Necessary, Medically Necessary Services, or Medical Necessity: Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards as described in the Covered Benefits section. Medical necessity, when used in relation to services, shall have the same meaning as medically necessary services. This definition applies only to the determination by Aetna of whether healthcare services are covered benefits.

Plan Administrator: For the purposes of most benefits described in this Summary Plan Description (SPD), all references to Plan Administrator refer to HCA Inc.

Precertification: The process of notifying the Claims Administrator before you receive care to ensure you receive the maximum benefits payable under the plan.

Mental or Behavioral Condition: A condition which manifests signs and/or symptoms which are primarily mental or behavioral, for which the primary treatment is psychotherapy; psychotherapeutic methods or procedures; and/or the administration of psychotropic medication; regardless of any underlying physical or medical cause. Mental or behavioral disorders and conditions include, but are not limited to: psychosis; affective disorders; anxiety disorders; personality disorders; obsessive-compulsive disorders; attention disorders with or without hyperactivity; and other psychological; emotional; nervous; behavioral or stress-related abnormalities associated with transient or permanent dysfunction of the brain; or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma; a physical or medical condition.

Negotiated Charge: The compensation amount negotiated between Aetna or an affiliate and a participating retail pharmacy, participating mail order pharmacy, or specialty pharmacy network pharmacy for medically necessary outpatient prescription drugs and insulin dispensed to a participant and covered under the participant's benefit plan. This negotiated compensation amount does not reflect or include any amount Aetna or an affiliate may receive under a rebate arrangement between Aetna or an affiliate and a drug manufacturer for any drug, including drugs on the drug formulary.

Non-Formulary Prescription Drug(s): A product or drug not listed on the drug formulary which includes drugs listed on the Drug Formulary Exclusions List.

Non-Hospital Facility: A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons except for transitional living facilities.

Out-of-Pocket Maximum: The most you pay during a plan year for eligible expenses under a benefit plan. Copayments do not count toward the annual out-of-pocket maximum.

Partial Hospitalization: The provision of medical; nursing; counseling; or therapeutic services on a planned and regularly scheduled basis in a hospital or non-hospital facility which is licensed as an alcohol or drug abuse or mental illness treatment program by the appropriate regulatory authority, and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care.

Participating Mail Order Pharmacy: A pharmacy, which has contracted with Aetna or an affiliate to provide covered outpatient prescription drugs or medicines, and insulin to participants by mail or other carrier.

Participating Retail Pharmacy: A community pharmacy which has contracted with Aetna or an affiliate to provide covered outpatient prescription drugs to participants.

Physician: A duly licensed participant of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides medical services which are within the scope of the individual's license or certificate.

Precertification Program: For certain outpatient prescription drugs, prescribing physicians must contact Aetna or an affiliate to request and obtain coverage for such drugs. The list of drugs requiring precertification is subject to change by Aetna or an affiliate. An updated copy of the list of drugs requiring precertification shall be available upon request by the participant or may be accessed at the Aetna Web site on the Benefit Providers page at HCArewards.com.

Premium: The amount HCA or participant is required to pay to Aetna to continue coverage.

Primary Care Physician: A participating physician who supervises; coordinates; and provides initial care and basic medical services as a general or family care practitioner; or in some cases, as an internist or a pediatrician to participants, initiates their referrals for specialist care, and maintains continuity of patient care.

Reasonable Charge: The charge for a covered benefit which is determined by Aetna to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. Aetna may take into account factors such as the complexity; degree of skill needed; type or specialty of the provider; range of services provided by a facility; and the prevailing charge in other areas in determining the Reasonable Charge for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.

Referral: Specific directions or instructions from a participant's PCP, in conformance with Aetna's policies and procedures, that direct a participant to a participating provider for medically necessary care.

Residential Treatment Facility – (Mental Disorders): This is an institution that meets all of the following requirements:

- On-site licensed behavioral health provider 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a physician.
- Has access to necessary medical services 24 hours per day/7 days a week.

- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
- Has peer-oriented activities.
- Services are managed by a licensed behavioral health provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission. Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

Residential Treatment Facility – (Alcoholism and Drug Abuse): This is an institution that meets all of the following requirements:

- On-site licensed behavioral health provider 24 hours per day/7 days a week
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a physician.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the participant requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending physician.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
- Has peer-oriented activities.
- Services are managed by a licensed behavioral health provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours per day/7 days a week supervision by a physician with evidence of close and frequent observation.
- On-site, licensed behavioral health provider, medical or substance abuse professionals 24 hours per day/7 days a week.

Respite Care: Care furnished during a period of time when the participant's family or usual caretaker cannot, or will not, attend to the participant's needs.

Section 125 Plan: See “Cafeteria Plan”

Self-Injectable Drug(s): Prescription drugs that are intended to be self administered by injection to a specific part of the body to treat certain chronic medical conditions. An updated copy of the list of covered self-injectable drugs, designated by Aetna as eligible for coverage under this plan, shall be available upon request by the participant or may be accessed at the Aetna Web site on the Benefit Provider page at HCArewards.com. The list is subject to change by Aetna or an affiliate.

Skilled Nursing: Services that require the medical training of and are provided by a licensed nursing professional and are not custodial care.

Skilled Nursing Facility: An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Skilled nursing facility does not include institutions which provide only minimal care, custodial care services, ambulatory or part-time care services, or institutions which primarily provide for the care and treatment of mental illness and substance abuse. The facility must qualify as a skilled nursing facility under Medicare or as an institution accredited by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, the Commission on the Accreditation of Rehabilitative Facilities, or as otherwise determined by the health insurer to meet the reasonable standards applied by any

of the aforesaid authorities. Examples of skilled nursing facilities include rehabilitation hospitals (all levels of care, e.g. acute) and portions of a hospital designated for skilled or rehabilitation services.

Specialist: A physician who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

Specialty Pharmacy Network: A network of participating pharmacies designated to fill self-injectable drugs prescriptions.

Step Therapy Program: A form of precertification under which certain prescription drugs will be excluded from coverage, unless a first-line therapy drug(s) is used first by the participant. The list of step therapy drugs is subject to change by Aetna or an affiliate. An updated copy of the list of drugs subject to step therapy shall be available upon request by the participant or may be accessed at the Aetna Web site on the Benefit Providers page at HCArewards.com.

Substance Abuse: Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Substance Abuse Rehabilitation: Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individualized treatment plans.

Totally Disabled or Total Disability: A participant shall be considered Totally Disabled if:

- The participant is a participant and is prevented, because of injury or disease, from performing any occupation for which the participant is reasonably fitted by training; experience; and accomplishments; or
- The participant is a covered dependent and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

Urgent Care: Non-preventive or non-routine healthcare services which are covered benefits and are required in order to prevent serious deterioration of a participant's health following an unforeseen illness, injury or condition if: a) the participant is temporarily absent from the Aetna Service Area and receipt of the healthcare service cannot be delayed until the participant returns to the Aetna Service Area; or b) the participant is within the Aetna Service Area and receipt of the healthcare services cannot be delayed until the participant's PCP is reasonably available.